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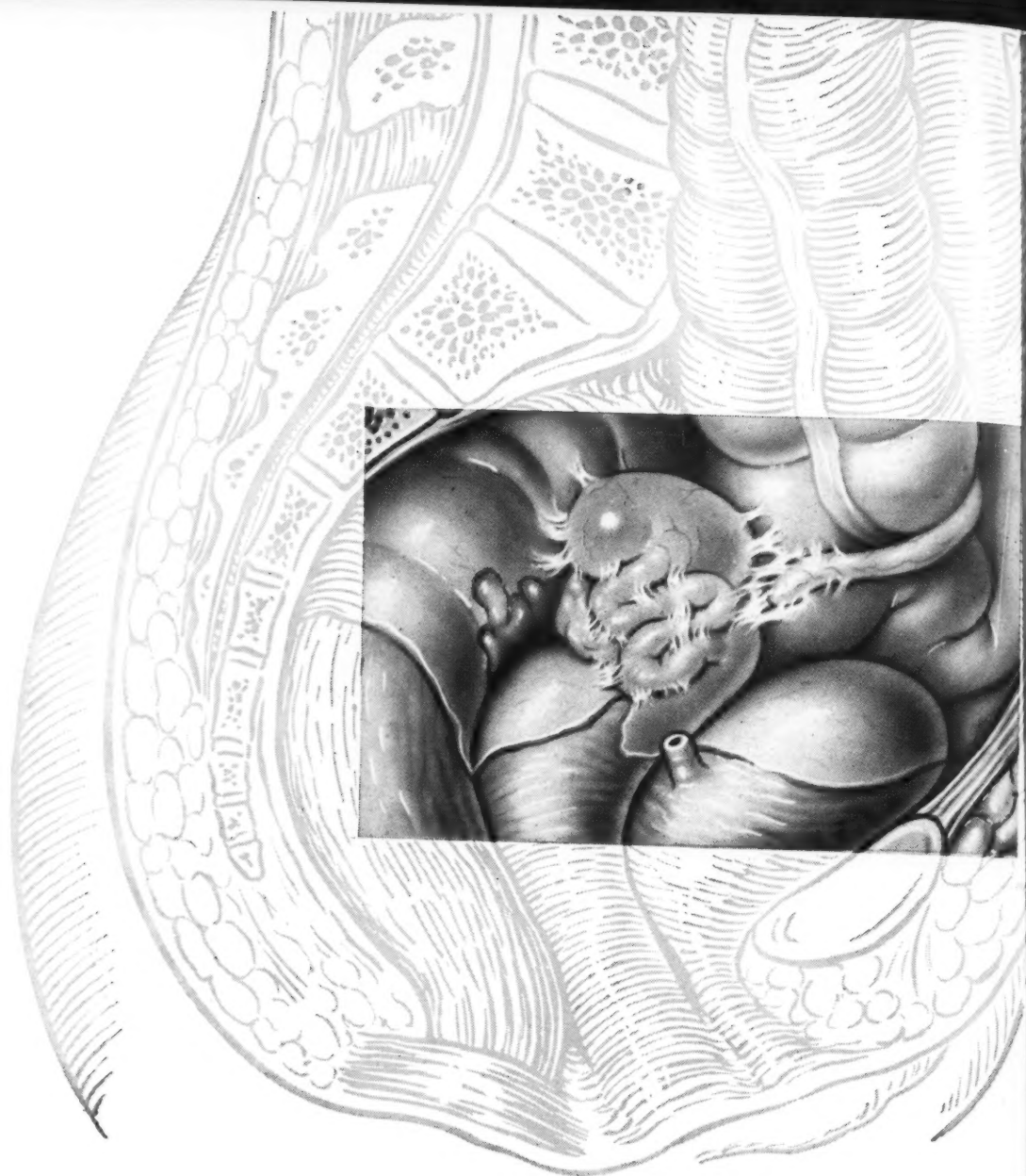
Volume 51

June, 1952

Number 6



(See page 736)



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THE JOURNAL

of the Michigan State Medical Society

VOLUME 51

JUNE, 1952

NUMBER 6

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Table of Contents

Principles of Good Clinical Anesthesia. <i>E. M. Papper, M.D.</i>	689
Then and Now. <i>Neal R. Moore, M.D.</i>	693
Vertigo. <i>J. Lewis Dill, M.D.</i>	699
Headaches. <i>Russell N. DeJong, M.D.</i>	701
Chronic Intestinal Disease. <i>Thomas T. Mackie, M.D.</i>	708
Acute Abdominal Conditions. <i>Charles R. Doyle, M.D.</i>	715
Diabetic Coma. <i>Alexander Marble, M.D.</i>	717
The Treatment of Alcoholism in an Out-patient Clinic. <i>Frank A. Cellar, M.D., and Abraham H. Grant, M.D.</i>	722
Doctors' Fees and the Wage Earner's Dollar. <i>Norman E. Clarke, M.D.</i>	724
Poliomyelitis and Injections. <i>Mario S. Cioffari, M.D.</i>	727
Detroit Physiological Society and the Society of the Sigma Xi: Meeting of April 24, 1952.....	730
President's Page.....	732
Editorial: We Are Proud to Report.....	733
Formula for Freedom.....	733
Government Inefficiency or Ineptitude.....	734
Michigan Medical Service: You Built It!.....	736
These Are the People.....	746
Officers and Directors.....	756
Michigan State Medical Society: Past Presidents 1866-1951.....	758
Official Call.....	759
Tentative Outline of 1952 Assembly Session Speakers.....	760
Information.....	761
House of Delegates—Order of Business.....	762
Delegates and Alternates.....	764
Reference, Credentials and Press Relations Com- mittees.....	767
Annual Report of Legislative Committee.....	768
Michigan's Department of Health.....	772
Correspondence.....	774
In Memoriam.....	776
News Medical.....	778
The Doctor's Library.....	789
You and Your Business.....	650
Heart Beats.....	660
Beaumont Memorial Contributors.....	664
Cancer Comment.....	672
Workers' Medical Problems Reviewed on Michigan Industrial Health Day.....	674
Formula for Freedom Nights.....	676
Editorial Comment.....	678
Federal Medicine.....	682

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JUNE, 1952

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Copyright, 1952, by Michigan State Medical Society

Published monthly by the Michigan State Medical Society as its official journal at 2642 University Avenue, Saint Paul 4, Minnesota.

Entered at the post office at Saint Paul, Minnesota, as second class matter, May 7, 1930, under the Act of March 3, 1879.

Acceptance for mailing at special rate of postage provided for in Section 1103 Act of October 3, 1917, authorized August 7, 1918.

Yearly subscription rate, \$5.00; single copies, 50 cents. Additional postage; Canada, \$1.00 per year; Pan-American Union, \$2.50 per year; Foreign, \$2.50 per year.

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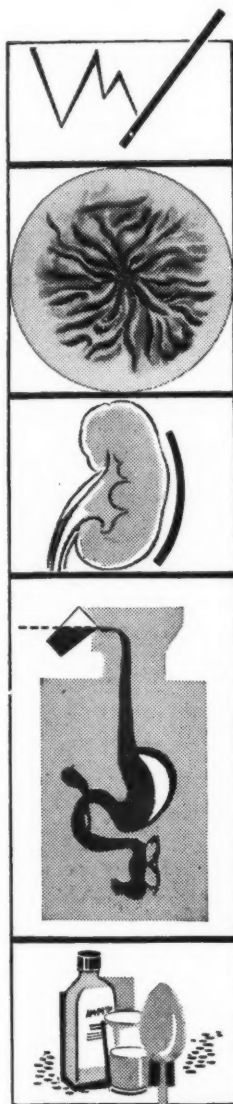
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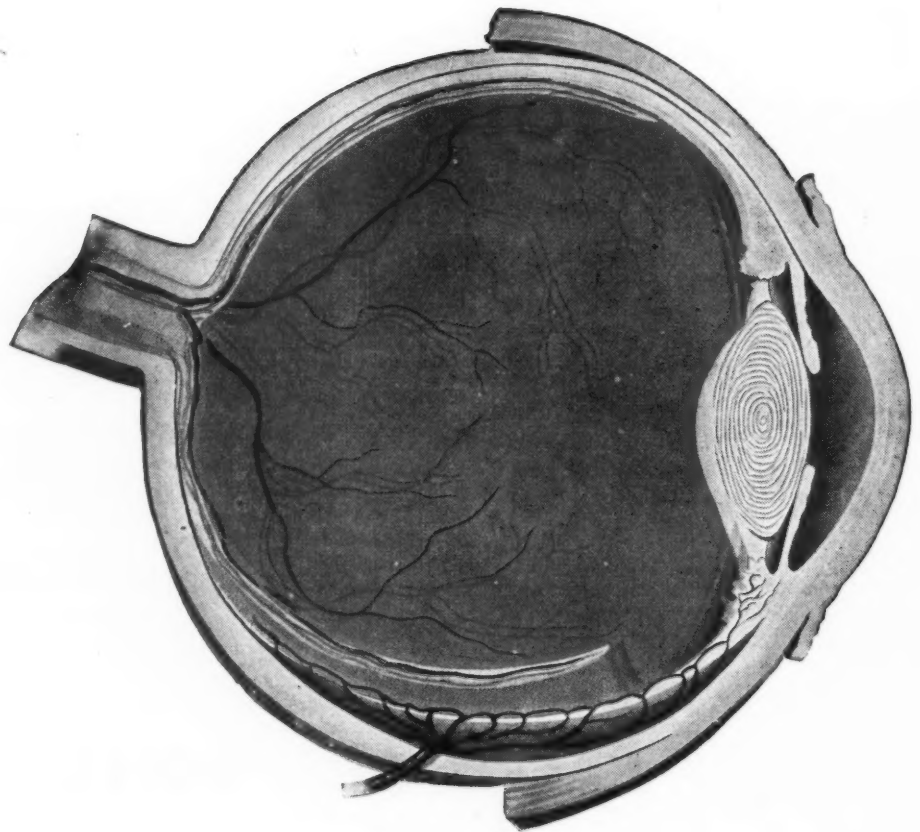
The shoe should be made to conform to the requirements of the individual foot;
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TERRAMYCIN ELIXIR, 250 mg. per teaspoonful.

1. Mitsui, Y., et al.: *Antibiotics & Chemotherapy* 1:253 (July) 1951.

2. Mitsui, Y., and Tanaka, C.: *Antibiotics & Chemotherapy* 1:146 (May) 1951.

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You and Your Business

MICHIGAN STATE MEDICAL SOCIETY ANNUAL SESSION

DETROIT—September 24-25-26, 1952

SUPPORT AMERICAN MEDICAL EDUCATION FOUNDATION

The support of every Doctor of Medicine is needed to insure the success of the American Medical Education Foundation. This noteworthy project is of the utmost importance to the medical profession. The Council of the Michigan State Medical Society has urged that all county medical societies and individual doctors not only maintain an active interest in the American Medical Education Foundation but contribute generously to its support.

Doctor, the Foundation is proof that the voluntary way is the only way for Medicine in the United States.

HIGHLIGHTS OF EXECUTIVE COMMITTEE OF THE COUNCIL

Meeting of April 23, 1952

Seventy-three items were presented to the Executive Committee of The Council on April 23 in Detroit. Chief in importance were:

- Financial reports were presented, studied, and approved.
Purchase of short term U. S. Treasury Certificates of Indebtedness, out of temporary surplus from 1952 dues, was authorized.
Bills payable were presented and approved for payment.
The Cancer Control Committee's financial report for the first quarter of 1952 was presented and approved.
- Group health and accident insurance for MSMS members. Finance Chairman W. S. Jones, M.D., reported on his April 8 Chicago conference with a firm of insurance brokers who will present a plan to the Executive Committee of The Council on May 24.
- Purchase of property in Lansing next to 606 Townsend Street. Completion of this transaction, previously authorized, will be made in a week to ten days; thus the MSMS property will

be rectangularized with 126 feet on Townsend Street and 100 feet on Hillsdale Street.

- The purchase of swing wing panels for photographs of past presidents, to hang in the Past Presidents Room in the MSMS "home" in Lansing, was authorized. All but four photographs of MSMS past presidents have been secured.
- A joint meeting with Michigan's delegates to the American Medical Association resulted in discussion of: (a) Oregon State Medical Society letter re military service call-ups; (b) role of the hospitals and their financial plight; and (c) study of proposed reorganization of the American Medical Association, with the following committee appointed to make this study: R. A. Johnson, M.D., Detroit, Chairman, W. D. Barrett, M.D., Detroit, J. S. DeTar, M.D., Milan, R. L. Novy, M.D., Detroit, G. C. Penberthy, M.D., Detroit, and C. E. Umphrey M.D., Detroit.
- Committee reports were given consideration as follows: (a) Permanent Conference Committee, meeting of March 19; (b) Rheumatic Fever Control Committee, meeting of March 26; (c) Geriatrics Committee, meeting of April 2; (d) Emergency Medical Service Committee, meeting of April 2; (e) Liaison Committee with Michigan Medical Service, meeting of April 16; (f) Special Committee to meet with Basic Science Board, meeting of April 23. In addition, Secretary L. Fernald Foster, M.D., reported on the successful county society executive secretaries' conference held at the Lansing MSMS headquarters, April 16, with the executive secretaries of Genesee, Muskegon, Saginaw, Washtenaw and Wayne County Medical Societies present.
- President Otto O. Beck, M.D., Birmingham, reported that contributions to the Beaumont Fund to April 23, 1952, totaled \$12,710.50. Dr. Beck stated that a total of \$40,000 from the profession is necessary to build the Beaumont Memorial on Mackinac Island. The President recommended that the names of all contributors to the Beau-

(Continued on Page 652)



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MICROWAVE DIATHERMY

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HIGHLIGHTS OF THE COUNCIL

(Continued from Page 650)

mont Fund be published in *THE JOURNAL MSMS*, which suggestion was approved by the Executive Committee of The Council.

- Committee appointments: Sibley W. Hoobler, M.D., Ann Arbor, to the Beaumont Memorial Resoration Committee; Perry C. Gittens, M.D., Detroit, to the Geriatrics Committee; Goldie P. Corneliuson, M.D., Lansing, to the Maternal Health Committee.
- The Public Relations Counsel's report included progress in MSMS television, radio and cinema activity; the active Formula For Freedom Night schedule; meeting of the Public Relations Advisory Committee to the AMA held in Chicago, April 14 and 15; and the final report of the MSMS Legislative Committee.
- The Executive Committee of The Council placed on its minutes a vote of approval and thanks to Public Relations Counsel H. W. Breneman and to Field Secretaries Daniel E. Ford, Stuart A. Campbell and John B. Kantner for their excellent work in interpreting the requirements of the 1951 MSMS House of Delegates re amendments to the Michigan Medical Practice Act and to the Basic Science Act.
- Request of the Michigan State Medical Assistants Society for listing of their membership in the JMSMS Roster Number and also for the printing of their convention program in the official MSMS Annual Session Program, was approved.
- The personnel of the 1953 Michigan Clinical Institute Committee on Arrangements and Program was appointed by the Executive Committee of The Council: J. M. Robb, M.D., Detroit, Chairman; W. D. Barrett, M.D., Detroit; R. J. Hubbell, M.D., Kalamazoo; Otto O. Beck, M.D., Birmingham; L. Fernald Foster, M.D., Bay City; E. F. Sladek, M.D., Traverse City; G. C. Penberthy, M.D., Detroit; A. C. Furstenberg, M.D., W. O. Badgley, M.D., O. T. Mallery, M.D., H. H. Cummings, M.D., and J. M. Sheldon, MD., all of Ann Arbor; W. H. Huron, M.D., Iron Mountain; F. E. Luger, M.D., Saginaw; R. A. Frary, M.D., Monroe; A. B. Gwinn, M.D., Hastings; M. G. Becker, M.D., Edmore; A. E. Heustis, M.D., Lansing, E. I. Carr, M.D., Lansing.

MSMS PAST PRESIDENTS' PHOTOGRAPHS

The Council has taken action to place photographs of all MSMS Past Presidents (covering the years from 1866 on) in the Past Presidents' Room of the new MSMS "home" at 606 Townsend Street, Lansing.

Photographs of the following have not as yet been located:

1875—Wm. Brodie, M.D., Detroit
 1880—J. R. Thomas, M.D., Bay City
 1885—E. P. Christian, M.D., Wyandotte
 1922—W. T. Dodge, M.D., Big Rapids

If you have a photograph of any of the above-listed Past Executives of the Michigan State Medical Society, The Council would appreciate your contributing a print for the Past Presidents' Room; or if you know of some person who might be contacted, please inform the MSMS Executive Office, 606 Townsend Street, Lansing.

Thank you,
 THE COUNCIL,
 Michigan State Medical Society

Four more, representing Wayne University College of Medicine and the Wayne County Medical Society, were to be nominated by WCMS on May 5.

- William Henry Gordon, M.D., Detroit, was authorized to accept appointment as a member of the American Medical Association's voluntary medical advisory committee (in civil defense matters).
- Monthly reports of Editor Wilfrid Haughey, M.D., Battle Creek; Rheumatic Fever Co-ordinator Leon DeVel, M.D., Grand Rapids, and Legal Counsel J. Joseph Herbert, Manistique, were presented and approved.
- Frank A. Weiser, M.D., W. B. Harm, M.D., and E. G. Merritt, M.D., all of Detroit, were appointed MSMS representatives to the Planning Committee of The Nurses Regional Conference to be held in Detroit on May 23.
- Resolution re S.1140, now in the Federal Congress, was approved and transmitted to the American Medical Association with a copy to be forwarded to the National Doctors' Committee for Improved Federal Medical Services.

GROUP ENROLLMENT CAMPAIGN LAUNCHED

Blue Cross-Blue Shield will hold a statewide group enrollment campaign in Michigan this summer. Through this plan, Michigan Hospital Service-Michigan Medical Service coverage is made

(Continued on Page 654)

sulfonamide solution
for prevention and treatment of eye infections
in 30% concentration

Higher concentration—Sodium SULAMYD® Ophthalmic Solution provides sulfacetamide, a sulfonamide soluble to a concentration of 30% at physiologic pH.

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Excellent results—In eye injury—no loss of working time in 98.87 per cent of one series of 11,953 cases;
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GROUP ENROLLMENT CAMPAIGN LAUNCHED

(Continued from Page 652)

available to families who do not qualify through a group plan.

From experience gained in the campaign held last summer, Blue Cross-Blue Shield have worked out additional details which will make it easier for families to enroll right in their own community or by mail.

For further information, write to Blue Cross-Blue Shield, Washington Boulevard Building, Detroit, Michigan, attention of J. C. Ketchum.

FULL-TIME FIELD SECRETARY FOR HEALTH COUNCIL

The Michigan Health Council Board of Directors has taken action to create the position of full-time Field Secretary. The Board felt that such a person is necessary to serve better the communities throughout the state having local health councils and to expand further the MHC and Community Health Council activities.

STATISM DOOMS SIXTY-FIVE- YEAR-OLDS, DOCTORS TOLD

Persons over sixty-five should be free from geriatric (old age) slavery imposed on them by retirement regulations of statism. Dr. C. Paul White of Kewanee, outgoing president of the Illinois State Medical Society, said yesterday.

Speaking in the Sherman hotel at the society's 112th annual meeting, Dr. White assailed Oscar F. Ewing, federal security administrator. He accused Ewing of planning to socialize medicine through compulsory sickness insurance.

If that law ever becomes effective, he said, it would tend to make 12,000,000 Americans now over sixty-five the objects of involuntary charity because they would be excluded from provisions of the bill.

"Society and the business world, as determined by the federal security agency and public aid commission rulings, have retired folks at sixty-five as worn out machines," Dr. White declared.

"You and I know that a large percentage of them have many years of mental and physical stability left in which to complete a productive career.

"If the politicians must do something, let them release these people of sixty-five, condemned by law, from their geriatric slavery, by creating new and realistic standards by which one can measure their efficiency and thus restore their self-respect

and remove a very heavy burden from our tax-weary citizens."

Dr. White said many physicians contend there is a wide range—from 50 to 80—of individual variation in the age at which human beings become aged.

He also noted that in opposing the establishment of 65 years as the arbitrary age supposed to mean the end of all productive activity, medical authorities have observed that premature retirement frequently hastens ultimate collapse into senility and death.

"Very definitely," said Dr. White, "sixty-five years is not the ultimate goal." In his talk on "American Medicine on the March," he reviewed health achievements made during the last 50 years and said these accomplishments prove the effectiveness of the free profession, which is learning to make people ever healthier and happier.—*Chicago Daily Tribune*, Thursday, May 15, 1952.

HOSPITAL COMMISSION OUTLINES COURSE OF TWO-YEAR INVESTIGATION

The Commission on Financing of Hospital Care, a non-government group financed by private subscription, has decided on a pattern to be followed in its two-year study of hospital costs. Although the survey was conceived by American Hospital Association, it is now being handled entirely by the Commission.

Commission Chairman Gordon Gray said a large part of the organization's budget and staff resources will be devoted to finding answers to the following:

1. What are the factors making for rising costs of hospitalization . . . and how can physicians and hospitals help to keep costs down?
2. How can hospital care be more satisfactorily financed for moderate income families and individuals?
3. How can prepayment plans further serve the interests of the public and hospitals?

The Commission also will investigate length of stay, utilization of X-ray and laboratory services, rehabilitation, the chronically ill, and financial and other problems involved in the use of expensive drugs and antibiotics.

DOCTOR, YOUR STATISTICS ARE SHOWING

The AMA's Membership Department has gone mechanical. To facilitate the processing of membership records, more than 350,000 IBM cards—approximately two and one-third cards per AMA member—have been added to the Department's files. These cards contain statistics such as the physician's dues payment, specialty, medical school, date of graduation, address and birth date. This new system will make possible a record of membership which can be readily tabulated and processed.

(Continued on Page 656)



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GROWING CHILDREN . . . FOR INVALIDS AND
UNDERNOURISHED PERSONS . . . FOR ANYONE
WHOSE DIETARY NEEDS INDICATE THE INGESTION
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CHANGES IN THE MEMBERSHIP AND FELLOWSHIP STRUCTURE OF THE AMERICAN MEDICAL ASSOCIATION 1949-1952

- 1918 Prior to 1950, and since the year 1918, all physicians who were active members of to their State Society were non-dues paying members of the American Medical Association.
- 1949 Of the 144,211 members of the A.M.A. in June, 1949, 77,723 were listed as fellows. Fellows paid dues to the A.M.A. and received THE JOURNAL A.M.A.
- 1949 The House of Delegates of the A.M.A. assessed all members of the A.M.A. \$25.00, but this assessment was voluntary and not compulsory. This was the only assessment made.
- 1950 There was no assessment in 1950. The A.M.A., for the first time, set the dues for membership in the A.M.A. at \$25.00 a year. If these dues were not paid by the end of the year the member was dropped for nonpayment; before he could be reinstated, it was necessary for him to pay the delinquent year's dues.
The 1950 dues did not include a subscription to THE JOURNAL A.M.A.
A member in 1950 again had to pay fellowship dues to receive THE JOURNAL A.M.A., or could subscribe to it separately.
- 1951 The membership dues in the A.M.A. in 1951 were \$25.00 and included a subscription to THE JOURNAL A.M.A. Fellowship dues were reduced but no longer included a subscription to THE JOURNAL A.M.A.
- 1952 The same as 1951, except that there are no fellowship dues and fellowship cards are not being issued. Fellowship will probably be abolished after the Annual Meeting of the A.M.A. in June, 1952.
The following summary will further clarify the changes from 1949 to 1952:

YEAR	MEMBERSHIP IN THE AMERICAN MEDICAL ASSN.	FELLOWSHIP IN THE AMERICAN MEDICAL ASSN.	SUBSCRIPTION PRICE OF THE JOURNAL A.M.A.
	Membership dues in the A.M.A. never included Fellowship dues. Membership dues have been payable only through the County and State Societies.	Fellowship in the A.M.A. was dependent upon membership in the State and County Societies and the A.M.A. Fellowship dues were payable to the A.M.A. and were in addition to the membership dues.	Since January 1, 1951, the price of THE JOURNAL has been included in membership dues; rates below for 1951 and 1952 are for non-members, and laymen. Anyone may subscribe to THE JOURNAL.
1949	Assessed \$25.00 but payment not compulsory.	Dues of \$12.00 included THE JOURNAL A.M.A.	\$12.00
1950	Dues of \$25.00 did not include THE JOURNAL.	Dues of \$12.00 included THE JOURNAL.	12.00
1951	Dues of \$25.00 included THE JOURNAL.	Dues of \$5.00 did not include THE JOURNAL.	15.00
1952	Dues of \$25.00 include THE JOURNAL.	No fellowship dues for 1952	15.00

MILLIONS PLEDGED BY U. S. TO HOSPITALS

Hill-Burton hospital construction summary for the end of March gives the total federal contribution to all projects (completed, in operation, under construction or only initially approved) at \$483 million, with the final cost—federal and local—set at \$1,353 million. In all, 1,773 projects (85,012 beds) have been processed since start of the H. B. program. Below is a summary of the status of all construction:

	Total Projects	Total Cost	Federal Cost	Beds Added
Completed	850	\$440,643,376	\$141,390,874	29,969
Under construction	762	762,544,996	286,654,490	46,573
Initially approved	161	149,559,082	55,028,800	8,470

ATOMIC ENERGY COMMISSION RELEASES FIVE-YEAR SUMMARY OF U. S. ISOTOPE DISTRIBUTION

More than 600 universities, hospitals and research laboratories in forty-six states are using isotopes produced by the U. S. Atomic Energy Commission for medical, biological, industrial, agricultural and scientific research and medical diagnosis and treatment, states the Commission-issued report, "Isotopes—A Five Year Summary of U. S. Distribution," which is available to the public from the Superintendent of Documents, U. S. Government Printing Office, Washington 25, D. C., for \$1.00 per copy. A summary of isotope applications considered to be of significance to industry has been compiled from the Five Year Summary and

(Continued on Page 658)



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Pyribenzamine[®] is *unsurpassed* in allergic rhinitis . . .

in urticaria
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ATOMIC ENERGY COMMISSION RELEASES FIVE-YEAR SUMMARY OF U. S. ISOTOPE DISTRIBUTION

(Continued from Page 656)

printed separately as document TID-5078 available at the Office of Technical Services, Department of Commerce, Washington 25, D. C., for 30 cents per copy.

The full report on isotope distribution for five years shows more than 18,900 shipments of radioactive isotopes and 1,500 stable isotopes have been made to users in the United States and 1,100 radioactive isotope shipments to users outside the United States.

A brief summary of the growth of the isotopes program and descriptions of their uses are included in the report with a list of the users and the titles of 1,400 technical reports and papers published on isotope work in the past two years.

The vice of capitalism is that it represents the unequal sharing of blessings; whereas the virtue of socialism is that it stands for the equal distribution of misery.—WINSTON CHURCHILL.

All important laboratory examinations; including—

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MEDICAL MEETINGS AND CLINIC DAYS

A list of known medical meetings and clinic days, sponsored by county medical societies and other physicians' groups in Michigan, follows:

1952

Spring MSMS Postgraduate Extramural Courses
State-wide
June 9-13 AMA Annual Session.....Chicago
June 27-28 Upper Peninsula Medical Society Annual
Meeting.....Iron Mountain
June St. Clair County Medical Society Clinic
Day.....St. Clair
July 24-25 Annual Collier-Penberthy Medical Sur-
gical Conference.....Traverse City
July 24-26 Conference on Housing of the Aging
Ann Arbor
August 21 Third Annual Clinic, Central Michigan
Committee, ACS Michigan Committee
on Trauma, plus Michigan National
Guard Medical Personnel, and Med-
ical Society of North Central Counties
Grayling

Sept. 24-26 MICHIGAN STATE MEDICAL SO-
CIETY ANNUAL SESSION.....Detroit
Oct. 8 Clara Elizabeth Fund—Genesee County
Medical Society—Lectures of 1952...Flint
Oct. 9 Fourth Michigan Cancer Conference
Kellogg Center, East Lansing
November American Academy of General Practice
of Wayne County.....Detroit
Autumn MSMS Postgraduate Extramural Courses
State-wide

1953

April 8 Genesee County Medical Society Eighth
Cancer Day.....Flint
May 13 Annual Clinic Day and Reunion of
Wayne University College of Medicine
Hotel Fort Shelby, Detroit

Additions to this list of meetings are invited by the Editor of JMSMS, in order to make this monthly announcement complete and accurate.

Oscar C. Pogge, director of Bureau of Old Age and Survivors Insurance, reports that 4,600,000 persons now are on OASI rolls; the total will be 7,195,000 by 1960 and by the year 2000 it will be 19,872,000.

How to Get

COMPLETE STERILIZATION

in LESS TIME than Simple Boiling

Bacteriologists and other authorities agree

- 1) That boiling merely sanitizes, or makes objects sanitary.
- 2) That only autoclaving, by utilizing steam under pressure, actually sterilizes, or completely destroys every form of life, harmful or innocuous.

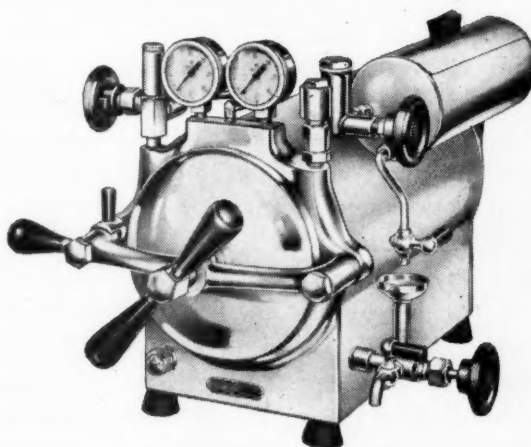
And *now* that safe autoclaving, by means of the Pelton FL-2, can be accomplished in less time than simple sanitization by boiling

water, why should any private office risk the danger of serious cross-infection from spore-bearing bacteria?

In addition, FL-2 autoclaving assures safe sterilization of absorbent materials, dressings and solutions. Needles, too, can be removed from the autoclave completely sterilized and perfectly dry, inside and out. Delicate instruments stay sharper, last longer, when autoclaved.

SEE the **PELTON FL-2**

The FL-2 generates and then stores steam under pressure in its outer chamber ready for instant use. That means fast sterilizing. In all-day operation, current is off two-thirds of time. That means economy. One quart of water lasts one to several days without replenishing. Inner chamber is 6" x 12". Automatic controls, sturdy construction, lustrous chrome finish.



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Heart Beats

THE CARDIAC HOUSEWIFE LEARNS HOW TO LIVE

During the past two years the Michigan Heart Association has developed a very comprehensive program designed to be of aid to the Doctor of Medicine in the management of his women cardiac patients. It is called the Cardiac Housewife Program and has received the endorsement of the Michigan State Medical Society.

The initial study on the program was conducted by the Michigan Heart Association in co-operation with the Wayne University Home Economics Department in Detroit where it proved to be a very successful undertaking. From these studies, which were carried out under medical guidance, a complete course of instruction was developed which fills the medical doctor's prescription of "take it easy" by showing the homemaker with a cardiac disorder how to save as much as 75 per cent of her walking, 75 per cent of her movements and 60 per cent of her reaching while performing her daily household tasks.

This tremendous savings of time and energy, which is so vital to the cardiac patient, was accomplished by analyzing the daily work habits of women cardiac patients and recording each detail performed. Wasted motions and useless trips were pointed out; rearrangement of dishes and utensils was made; a cart to transport dishes and utensils was suggested. In the preparation of one meal alone, these simple changes resulted in cutting steps walked from 672 to 266, stooping from twenty to eight times, standing on tip-toe from forty-four to twenty-nine times. The total number of steps saved at preparing one meal alone were calculated to represent a savings of more than 62 miles of walking in a year. The patient became very motion conscious and was soon finding new short cuts by herself. She found that not only was her actual work-load decreased, but that she had more time in which to rest, for the more efficient method was also the shorter. The patient

informed us that she was now able to plan her rest periods rather than interrupt a job because dyspnea made her rest. She also was very happy because she said that she was now able to do more for herself, yet feel no fatigue at the end of the day. It was felt that this was proof that work-simplification was of value to a cardiac homemaker.

Accordingly, other cases were studied and the same interest generated in the patient. Our home economist consultant, meanwhile, was learning of the restrictions important to the cardiac. Pictures were taken, charts and graphs drawn of the changes in arrangement. Thus, visual teaching aids were obtained during the study of actual cardiac patients. It is these data which are now being offered in the Michigan Heart Association's course for cardiac homemakers. The changes suggested are inexpensive and the techniques taught can and do benefit any economic level.

Following the initial pilot study at Wayne University, formal classes were started and women cardiac patients were admitted to the free course of instruction upon recommendation of their family Doctor of Medicine. The free work-simplification classes being held at Wayne University under the auspices of the Michigan Heart Association, have been in operation for more than a year. During that time nearly 200 Detroit and Wayne County women cardiac patients have attended the demonstration-lectures.

Because of the success of the program in the Detroit area a grant of funds was made by the Michigan Heart Association to the School of Home Economics at Michigan State College in East Lansing to conduct a similar program for use throughout Michigan.

Accordingly, the classes were developed at Michigan State and offered to Lansing and Ingham County cardiac homemakers. After very favorable and highly successful results in the Ingham County area, the classes were extended last fall by the Michigan Heart Association, through the Extension Service of Michigan State College, to

(Continued on Page 662)

EDITOR'S NOTE: The Cardiac Housewife Program is an example of the splendid cooperation of an organization under the Know How To Live element of the Formula for Freedom. This action program has educational benefits that go far beyond the advice given to cardiac housewives.

Reasons for effectiveness of Furacin

A wide antibacterial spectrum, including many gram-negative and gram-positive organisms • Effectiveness in the presence of wound exudates • Lack of cytotoxicity: no interference with healing or phagocytosis • Low incidence of sensitization: less than 5% • Ability to minimize malodor of infected lesions • Stability.

Furacin® preparations contain Furacin 0.2% brand of nitrofurazone N.N.R. in water-miscible vehicles which dissolve in exudates.



IN CHRONIC VARICOSE ULCERS...

In a female aged 47 years, varicose ulcers had proven refractory to rest, elevation of the leg, compresses and diverse topical applications. There was profuse discharge with *Micrococcus pyogenes aureus*, *Streptococcus pyogenes*, *P. aeruginosa* (pyocyaneus) (Fig. 1).

October 15. Furacin Soluble Dressing applied. There was rapid diminution in drainage. The ulcers soon showed a clean, granulating surface.

December 10. Linton skin flap operation performed. Furacin Soluble Dressing used postoperatively.

February 26. Patient discharged (Fig. 2); complete healing two weeks later.

Literature on request

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THE CARDIAC HOUSEWIFE LEARNS HOW TO LIVE

(Continued from Page 660)

Berrien, Kent, Genesee, Isabella, Grand Traverse, Benzie, and Leelanau Counties where they were attended by 196 women cardiac patients. The program is being expanded as rapidly as possible and eventually will be available in every county of the state.

Plans have already been formulated to offer the work-simplification classes in the above counties again this spring. In addition, cardiac patients in Bay, Emmet, Charlevoix and Cheboygan Counties will also be served by the Cardiac Housewife Program. You and your local County Medical Society will be informed of the exact dates for the classes to be offered in your area. You may then refer your cardiac patients to the free classes.

No medical advice, treatment, diagnosis or examination is given to anyone in the classes. The course consists only of the adaptation of work-simplification techniques to the various household tasks performed by the housewife. The instruction offered will be of valuable assistance to you in prescribing relaxing work habits for cardiac patients.

In working with cardiac patients in the classrooms, two important factors have been realized from the instruction offered: (1) a new attitude of hopefulness on the part of the patient, resulting from the constructive attitude of emphasizing what can be done rather than what cannot be done, and (2) a reawakening of interest and spirit of helpfulness on the part of the husband and children in helping the disabled mother.

For further information and details regarding the classes held in the counties listed above, contact the following persons:

Bay County—Mr. Robert Stuart, Director Adult Education, Board of Education, Bay City.

Berrien County—Miss Ina Redman, 150 Water Street, Benton Harbor.

Emmet-Charlevoix-Cheboygan County—Mrs. Sidney Reinbold, Court House, Petoskey.

Genesee County—Mrs. Clara P. Hay, Court House, Flint 3.

Grand Traverse-Leelanau-Benzie County—Mrs. Edna Deo, Federal Building, Traverse City, or Leland.

Ingham County—Mrs. Ruth C. Kettunen, Home Management Department, Michigan State College, East Lansing.

Isabella County—Miss Josephine Brighenti, Federal Building, Mt. Pleasant.

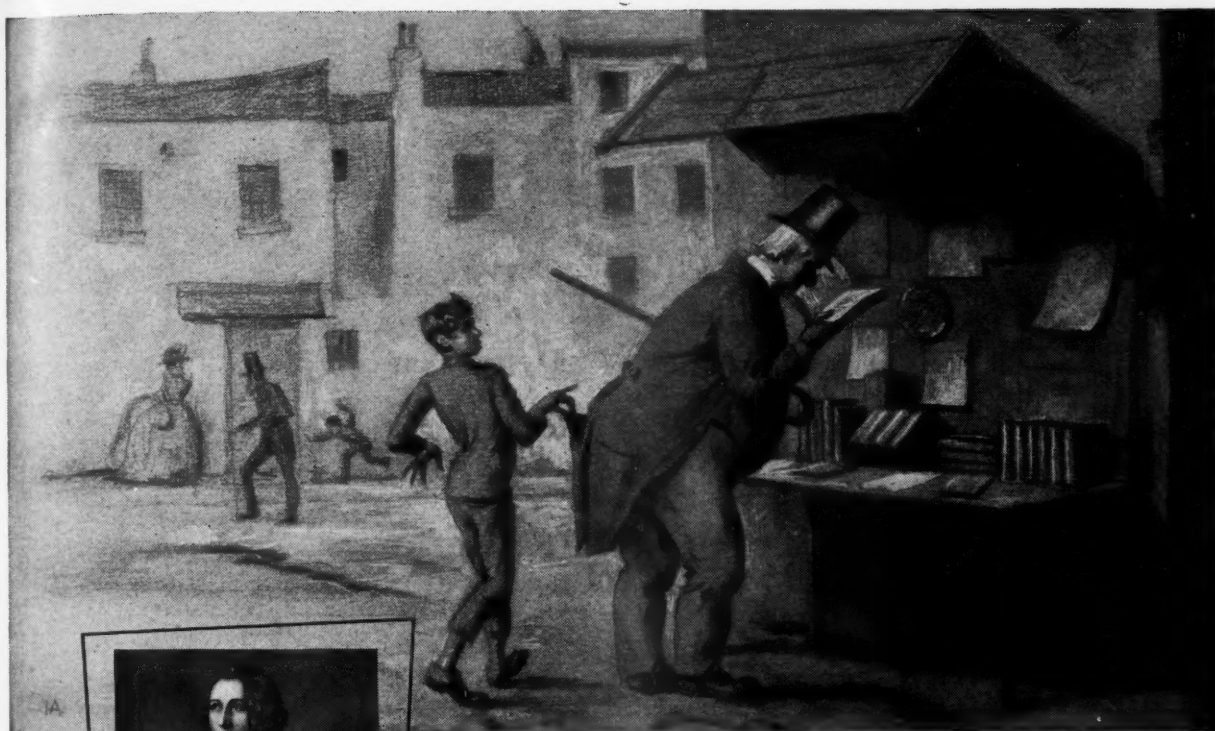
Kent County—Mrs. Ruth E. Mawby, Court House, Grand Rapids.

Wayne County—Michigan Heart Association, 4421 Woodward Avenue, Detroit 1.

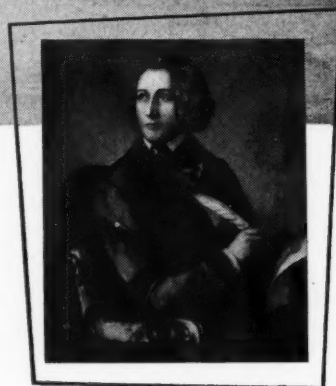


The Wayne University College of Medicine Senior Class visited Eli Lilly & Company on May 11, 12 and 13, 1952, at the Laboratory of Indianapolis and Greenfield.

There was an interesting program including dinner Sunday evening followed by entertainment. A full Monday and Tuesday program was enjoyed with breakfast, luncheon and dinner as guests of the Company.



Scene from "Oliver Twist"



CHARLES DICKENS
1812-1870

Psychoneurotic Men of Genius

Charles Dickens, the renowned British novelist, was subject to cyclic moods of pronounced depression characterized by intense nervous irritability and by the shedding of tears all day long. He was exceedingly sensitive to his own experiences as well as to the suffering of others.

In the great majority of psychoneurotics, there is no serious mental illness, but merely an emotional imbalance which often can be greatly improved by proper psychotherapeutic and sedative management. In the treatment of psychoneurosis, particularly agitated, depressed and anxiety states, Mebaral is preferred by many because it combines a high degree of sedative effectiveness—producing emotional stability—with a relative freedom from side effects such as languor and drowsiness. Patients usually become calmer, more cheerful and better adjusted to their surroundings without clouding of mental faculties.

Average sedative dose:

Adults, 32 mg. to 0.1 Gm. ($\frac{1}{2}$ to $1\frac{1}{2}$ grains)
three or four times daily;
children, 16 to 32 mg. ($\frac{1}{4}$ to $\frac{1}{2}$ grain)
three or four times daily.

Supplied in tablets of 32 mg.,
0.1 Gm. and 0.2 Gm.



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Beaumont Memorial Contributors

Michigan's doctors of medicine, through their generous contributions, are bringing closer to realization the plans of the Beaumont Memorial Restoration Committee to erect a symbol of wood and stone marking the location of a renowned advance in medical science.

This symbol—restoration of the American Fur Company store on Mackinac Island—will serve as a constant reminder to the public of the pioneering experiments of Dr. William Beaumont and of other medical men through the centuries.

The Michigan State Medical Society needs \$40,000 to rebuild the historic fur store where Alexis St. Martin was felled by the blast of a musket but who providentially lived with a natural window in his stomach. Through this fistula, Dr. Beaumont made his famous observations on the French-Canadian voyageur.

While individual doctors of medicine are responding to the request for funds, organizations within MSMS are contributing sizeable lump sums secured from their membership.

Besides the original contribution by Parke, Davis and Company of Detroit to purchase the Mackinac Island property, the largest single contributor to date has been the Genesee County Medical Society. The members raised a total of \$1,864 for the Beaumont Restoration project.

The generous contribution of \$500 by the Woman's Auxiliary to the Wayne County Medical Society also helped swell the total received up to May 31 to \$13,701.25.

The 795 individual doctors of medicine who have helped build the fund on towards the goal of \$40,000 have made average contributions of \$11.50.

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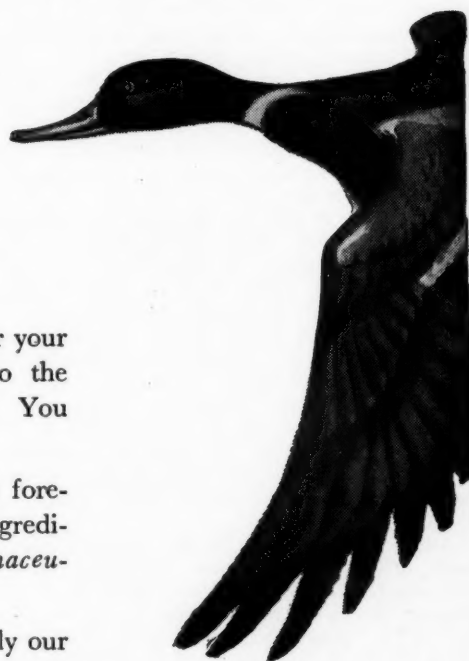
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(Continued on Page 668)

WHEN FOOD INTAKE *is inadequate*

When the patient's food intake is inadequate to supply essential nutrients in proper amounts, clinical experience has demonstrated the supportive value of a dietary supplement providing substantial quantities of virtually all needed nutrients—protein, vitamins, minerals, carbohydrate, and fat. The choice of the supplement prescribed, to a large extent, can determine the efficacy of the supplemented diet since over-all nutrient adequacy is the primary aim.

It is apparent from the data shown below that Ovaltine in milk can serve well in markedly increasing the intake of virtually all known nutrients. Taken daily during periods of inadequate consumption of other foods, it offers an excellent means for preventing subclinical nutritional deficiencies which can undermine general health or retard recovery from illness.

The appealing flavor of Ovaltine makes it acceptable to children as well as adults, including the aged. Ovaltine in milk is easily digested, an important feature when digestive disturbances are a factor.

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(Each serving made of ½ oz. of Ovaltine and 8 fl. oz. of whole milk)

MINERALS

*CALCIUM.....	1.12 Gm.
CHLORINE.....	900 mg.
COBALT.....	0.006 mg.
*COPPER.....	0.7 mg.
FLUORINE.....	3.0 mg.
*IODINE.....	0.7 mg.
*IRON.....	12 mg.
MAGNESIUM.....	120 mg.
MANGANESE.....	0.4 mg.
*PHOSPHORUS.....	940 mg.
POTASSIUM.....	1300 mg.
SODIUM.....	560 mg.
ZINC.....	2.6 mg.

VITAMINS

*ASCORBIC ACID.....	37 mg.
BIOTIN.....	0.03 mg.
CHOLINE.....	200 mg.
FOLIC ACID.....	0.05 mg.
*NIACIN.....	6.7 mg.
PANTOTHENIC ACID.....	3.0 mg.
PYRIDOXINE.....	0.6 mg.
*RIBOFLAVIN.....	2.0 mg.
*THIAMINE.....	1.2 mg.
*VITAMIN A.....	3200 I.U.
VITAMIN B ₁₂	0.005 mg.
*VITAMIN D.....	420 I.U.

*PROTEIN (biologically complete).....	32 Gm.
*CARBOHYDRATE.....	65 Gm.
*FAT.....	30 Gm.

*Nutrients for which daily dietary allowances are recommended by the National Research Council.

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RECORD NUMBER OF LIVE BIRTHS

Live births for 1951 may have topped the all-time high set in 1947, but U. S. Public Health Service is waiting for final returns before making formal announcement. The 1947 figure for live births was 3,818,000 and the 1951 unofficial total is 3,833,000 but PHS points out this is just an estimate and the totals are too close together to make any claims for 1951's birth rate without final figures. One of the factors contributing to the rise was the continuing decline in infant mortality. For the fifteenth straight year the infant death rate declined, reaching 28.8 per thousand live births last year.

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671

Cancer Comment

BREAST CANCER STUDIES

In unpublished data, Paul R. Gerhardt, M.D., and Irving D. Goldberg, B.S., Bureau of Cancer Control, New York State Department of Health, Albany, present some interesting information regarding incidence and control of breast cancer in that state.

In New York, exclusive of New York City, cancer has been reportable by legislative enactment since January 1, 1940. Reporting received the approval of the state medical society at its inception and has been supported actively since that time. Cancer reporting has proven useful in epidemiologic investigations; for evaluation of progress in cancer control; in public and professional education; in aiding tumor clinics in follow-up of patients; and in providing public health nursing service to cancer patients.

In New York, exclusive of New York City, breast cancer is the most frequently reported human malignant tumor, nearly 2,200 cases of breast cancer being reported yearly out of a total of almost 19,000 cases of all types. In the female population of that state, sixty cases of breast cancer per 100,000 population develop annually. This study showed that with increasing age both morbidity and mortality rates of female breast cancer increased. Some five per cent of the state's female population are expected to develop breast cancer after their 45th birthday. Breast cancer incidence is continuously rising and may be due, in part, to better reporting and other artificial factors. Mortality from this form of the disease apparently is lessening in recent years. This situation indicates that treatment is more effective and also may be due in part to such patients seeking diagnosis and treatment in earlier stages of development.

During the period under study, 1943-1949, radical mastectomy as the treatment of choice increased four per cent. Preoperative biopsies were reported for less than one-third of the cases in either year but most likely many table biopsies were done at the time of surgery that were never reported. The needle punch biopsy, quite popular in 1943, had been almost abandoned in 1949. Radical mastectomies increased markedly over simple mastectomies during this same period even

though in many cases, metastases to adjacent lymph nodes could not be demonstrated at time of operation.

In both 1943 and 1949 studies, the stage of the disease at time of diagnosis was the same. In 46 per cent of cases there were metastases to or beyond regional lymph areas. Only 30 per cent were classified as in early stages with no metastases. The authors emphasize that the most significant index of control in breast carcinoma is that which indicates the proportion of all breast cancers undergoing radical mastectomies before axillary node metastasis. Among their 1943 breast cases, 26 per cent had radical mastectomies without axillary metastases, while in 1949 this percentage had increased to 35, a 35 per cent increase in this important control index. This experience is borne out in other studies of a similar nature, indicating that the long continued and intensive lay education program, especially among women, may be showing favorable results.

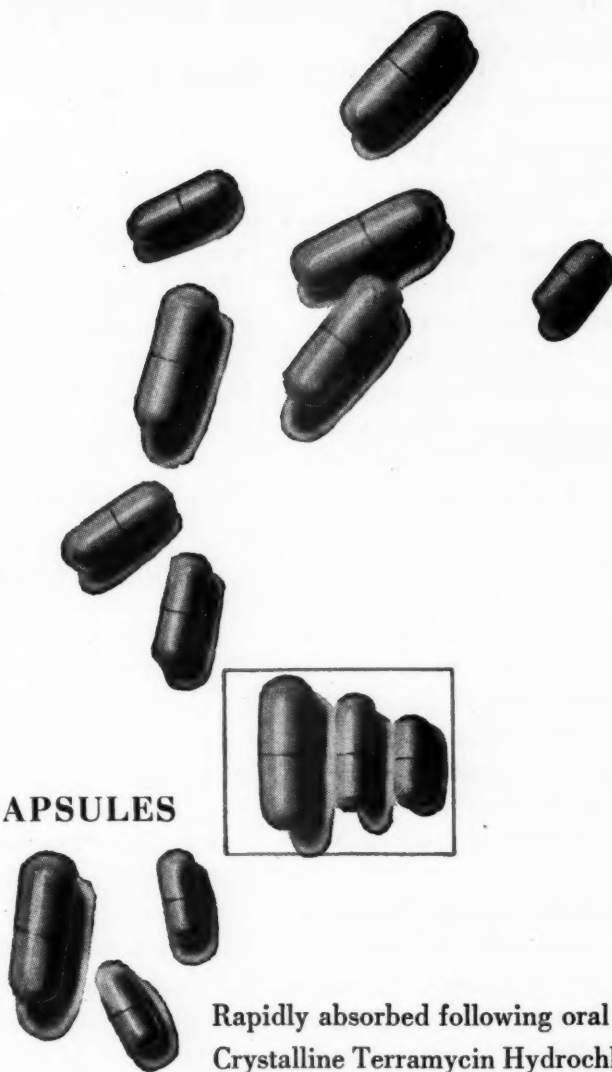
An important factor to be considered in this study is the availability of a large number of accurate and comparable cancer morbidity reports. Cancer reporting is approximately 80 per cent complete in New York and is due in large measure to the active co-operation of the medical profession. Professional interest in cancer control is further stimulated by fifty-three tumor clinics organized under the minimum standard requirements of the American College of Surgeons and operating in various cities outside New York City. These tumor clinics are organized into a state group which meets regularly for scientific discussion of cancer problems as well as holding professional education meetings in their own organization. These clinics are fully approved and supported by the Medical Society of the State of New York.

Further, the Roswell Park Memorial Institute, Buffalo, currently undergoing a building program to increase the bed capacity from 110 beds to 516 beds, is devoted to cancer research as well as clinical care of patients admitted by referral from their own physicians. The Institute is administered by the State Department of Health. It is adequately staffed for both clinical and research

(Continued on Page 674)

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Workers' Medical Problems Reviewed on Michigan Industrial Health Day

The health of Michigan's industrial workers was scrutinized by industrial physicians and surgeons on the Third Annual Industrial Health Day. Topics ranged from the workers' psychiatric conflicts to the types of shoes they should wear.

More than 200 doctors of medicine attended the one-day conference, May 7, which was conducted at Hurley Hospital and the Durant Hotel in Flint. Otto J. Preston, M.D., President of the Michigan Association of Industrial Physicians and Surgeons, presided at the sessions.

The program was climaxed in the evening at a banquet, sponsored by General Motors Corporation, in the Durant Hotel. The featured speaker at the annual banquet was Andrew C. Ivy, M.D., Professor of Physiology, University of Illinois. Dr. Ivy covered the topic of "The Physiological Background to the New Concepts of Artificial Respiration." Toastmaster at the banquet was Max R. Burnell, M.D., Medical Director of General Motors Corporation, Detroit.

T. I. Boileau, M.D., Detroit, assumed the presidency of the Michigan Association of Industrial Physicians and Surgeons for 1952-1953. Sherman Andrews, M.D., of Kalamazoo, was named President-Elect of the organization. The other officers elected at the annual business meeting were Paul J. Ochsner, M.D., Lansing, Vice President, and Edwin DeJongh, M.D., Lansing, Secretary-Treasurer.

During the day, nine Michigan leaders in industrial health presented scientific papers in the clinical section of the meeting. Joseph Shapiro, M.D., Flint psychiatrist, spoke on "Psychiatric Problems Observed in Industry." Paul C. Kingsley, M.D., Battle Creek orthopedic surgeon, discussed "Office Treatment of Common Foot Disorders as seen in Industry." Harold W. Woughter, M.D., Flint, Chief, Section of Surgery of Trauma, McLaren General Hospital, presented a paper on "Skin Coverage of the Hand." Walter Z. Rundles, M.D., Chief of Otolaryngology, Department of Surgery, Hurley Hospital, Flint, discussed "Clinical Use of the Audiometer in Industry."

E. A. Osius, M.D., Assistant Professor, Clinical Surgery, Wayne University College of Medicine,

Detroit, led off the afternoon session with a paper on "Venous Status of the Lower Extremities." Raymond M. Engleman, M.D., Chief, Division of Thoracic Surgery, McLaren General Hospital, Flint, discussed "Abnormal Chest Films Which Do Not Preclude Employment." George J. Curry, M.D., Chief, Section of Surgery of Trauma, Hurley Hospital, Flint, considered "Romance of Trauma." Otto T. Mallery, M.D., Associate Professor of Internal Medicine, University of Michigan Medical School, concluded the clinical program with a paper on "Recent Advances in Medical Education."

Those attending the conference from outside Michigan were Carl M. Peterson, M.D., Secretary, Council on Industrial Health, American Medical Association, Chicago; Edward C. Holmblad, M.D., Managing Director, Industrial Medical Association, Chicago; Maurice G. Woolff, M.D., General Motors, Port Elizabeth, South Africa; and Gerd Carow, M.D., of Germany.

The meeting was sponsored by the Michigan Association of Industrial Physicians and Surgeons, Michigan State Medical Society Committee of Industrial Health, American College of Surgeons, University of Michigan, Wayne University, and Michigan State Department of Health.

CANCER COMMENT

(Continued from Page 672)

studies, and as part of the equipment has approximately eight grams of radium.

To improve further the professional treatment and care of cancer patients in this state, Michigan physicians might well study in more detail the New York State Program of Cancer Control, especially their program of cancer reporting which enables emphasis to be placed on some of the weak spots in any cancer control program.

Patient history-taking is a difficult task but one which is highly remunerative in end results.

* * *

There is more rejoicing in heaven over the one laparotomy that fails to find cancer than over the ninety-nine that find it too late.

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Formula For Freedom Nights

At County Medical Societies

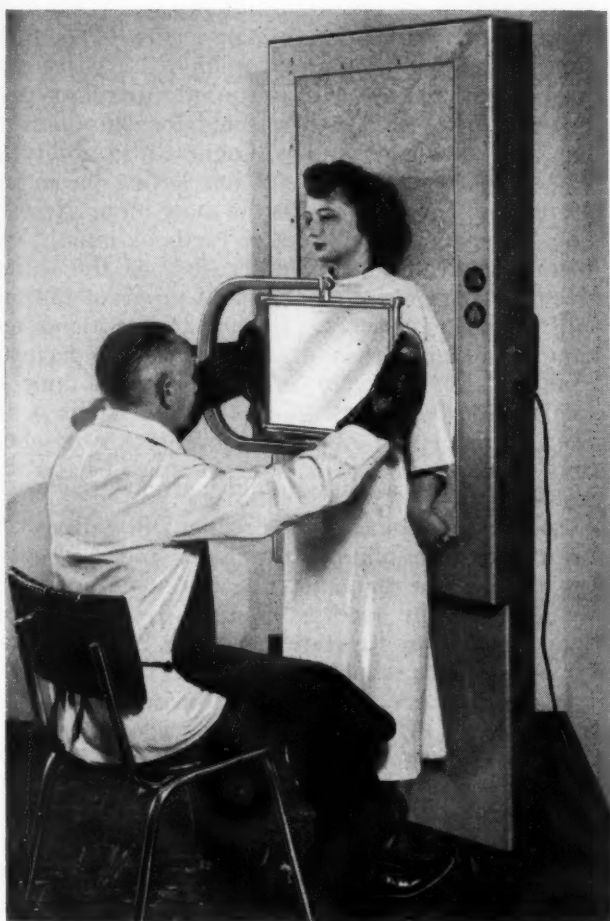
Date	Place	Speakers
Dec. 18, 1951	Kalamazoo Kalamazoo Academy of Medicine	R. J. Hubbell, M.D., Kalamazoo Otto O. Beck, M.D., Birmingham L. Fernald Foster, M.D., Bay City D. Hale Brake, Lansing State Treasurer Hugh W. Brenneman, Lansing
Jan. 15, 1952	Grand Rapids Kent County Medical Society	L. Fernald Foster, M.D., Bay City Senator Carlton H. Morris, Kalamazoo Hugh W. Brenneman, Lansing
Jan. 22, 1952	Saginaw Saginaw County Medical Society	L. Fernald Foster, M.D., Bay City J. E. Livesay, M.D., Flint H. B. Zemmer, M.D., Lapeer L. C. Harvie, M.D., Saginaw Hugh W. Brenneman, Lansing
Feb. 5, 1952	Big Rapids Mecosta-Osceola-Lake County Medical Society	L. Fernald Foster, M.D., Bay City Senator Milo A. Johnson, Greenville Hugh W. Brenneman, Lansing
Feb. 12, 1952	Owosso Shiawassee & Clinton County Medical Societies	L. Fernald Foster, M.D., Bay City Senator James M. Teahen, Jr., Owosso Hugh W. Brenneman, Lansing
Feb. 14, 1952	Ann Arbor Washtenaw County Medical Society	L. Fernald Foster, M.D., Bay City Bradley M. Harris, M.D., Ypsilanti D. Hale Brake, Lansing State Treasurer Hugh W. Brenneman, Lansing
Feb. 15, 1952	Muskegon Muskegon County Medical Society	L. Fernald Foster, M.D., Bay City William C. Vandenberg, Lansing Lt. Gov., State of Michigan Hugh W. Brenneman, Lansing
Feb. 19, 1952	Mt. Pleasant Gratiot-Isabella-Clare County Medical Society	L. Fernald Foster, M.D., Bay City Hugh W. Brenneman, Lansing
March 4, 1952	Battle Creek Calhoun County Medical Society	L. Fernald Foster, M.D., Bay City Senator Creighton R. Coleman, Marshall Hugh W. Brenneman, Lansing
March 7, 1952	Holland Ottawa County Medical Society	L. Fernald Foster, M.D., Bay City Senator C. H. Geerlings, Holland Hugh W. Brenneman, Lansing
March 18, 1952	Port Huron St. Clair and Sanilac County Medical Society	L. Fernald Foster, M.D., Bay City John B. Martin, Jr., Lansing Auditor-General, State of Michigan Hugh W. Brenneman, Lansing
March 19, 1952	Bay City Bay-Arenac-Iosco County Medical Society	D. Hale Brake, Lansing State Treasurer J. E. Livesay, M.D., Flint Hugh W. Brenneman, Lansing
April 1, 1952	Monroe Monroe County Medical Society	Bradley M. Harris, M.D., Ypsilanti D. Hale Brake, Lansing, State Treasurer Hugh W. Brenneman, Lansing
April 15, 1952	Flint Genesee County Medical Society	L. Fernald Foster, M.D., Bay City John B. Martin, Jr., Lansing Auditor-General, State of Michigan Joseph R. Hainline, Detroit
April 24, 1952	Hastings Barry County Medical Society	L. Fernald Foster, M.D., Bay City
April 24, 1952	South Haven Van Buren County Medical Society	L. Fernald Foster, M.D., Bay City Senator G. Elwood Bonine, Vandalia

Formula For Freedom Nights

At County Medical Societies

Continued

Date	Place	Speakers
May 6, 1952	Traverse City Grand Traverse-Leelanau-Benzie County Medical Societies	D. B. Wiley, M.D., Utica D. Hale Brake, Lansing, State Treasurer Hugh W. Brenneman, Lansing
May 27, 1952	Genesee County Medical Society Woman's Auxiliary	L. Fernald Foster, M.D., Bay City
May 29, 1952	Dowagiac Cass County Medical Society	L. Fernald Foster, M.D., Bay City Senator G. Elwood Bonine, Vandalia Hugh W. Brenneman, Lansing
June 5, 1952	Ann Arbor Michigan Tuberculosis Association Annual Meeting	L. Fernald Foster, M.D., Bay City D. Hale Brake, Lansing, State Treasurer Hugh W. Brenneman, Lansing
June 17, 1952	Lansing Ingham County Medical Society	D. Bruce Wiley, M.D., Utica Rep. Lawrence B. Lindemer, Stockbridge Hugh W. Brenneman, Lansing
June 27, 1952	Iron Mountain Annual Meeting, Upper Peninsula Medical Society	To be announced



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Editorial Comment

MICHIGAN STATE MEDICAL SOCIETY ANNUAL SESSION

SHERATON-CADILLAC HOTEL—DETROIT

September 24-25-26, 1952

64 YEARS AND 364 DAYS

Talking with one of our doctors at lunch at the recent Michigan Clinical Institute the talk casually turned to medical student days and classmates and the doctor, one of our honored and distinguished, remarked the year of his graduation—he didn't seem that old—and surprise and implied doubt were mentioned. To emphasize the year of his graduation he said that he had reached 65 the previous year at which time retirement was compulsory from the active staff of his hospital. He belies his years in appearance, activity, and more importantly in the retention of his mental faculties.

Biological age and retention of mental vigor do not parallel the years ticked off on the calendar. Some people have psychological true old age with fixed accompanying patterns of senescence before pubescent tempers have cooled. By what rule of reason and common sense is a man able to be head of a medical or surgical service at 64 years and 364 days, and the next day he considered as inadequate, a has been?

Medicine instead of taking directives from business and industry should set the pattern for industry in this increasing problem of compulsory rule of retirement at a fixed age. Stereotypy is recognized as a symptom, regardless of whence it comes.

Everyone can name some of the great in the golden book of achievement in science, and art, and literature who continued or made their greatest contributions in the 6th, and 7th, and 8th decades.

The big accelerating waste of our mechanical age is the loss of the wisdom and creative and productive output of those who have only by the decree of the passage of time been relegated to the junk heap, so to speak, with the stamp of finality—pensioned, retired, emeritus! By what mis-rule of reason and common sense is a doctor able to be a senior medical or surgical staff-man at 64 years and 364 days and by administrative fiat the next day be considered inadequate, a has been, incapable. Who's telling who?

Look around. Some of the older doctors with the wisdom and ability acquired through a lifetime possess an entirely modern and up to the minute grasp of medicine. And they shine with the joie de vivre.

This tragic loss that industry indulges should not be transposed to and fatalistically and objectively,

and silently accepted by medical men. No group is better fitted to mold and direct its own destiny.

Sixty-four years and 364 days is a variable and shifting milestone. While in some it post dates an era, in many it is but another day in a busy useful life.—DAVE SUGAR in *Detroit Medical News*, April 21, 1952.

TRAINING OR EDUCATION?

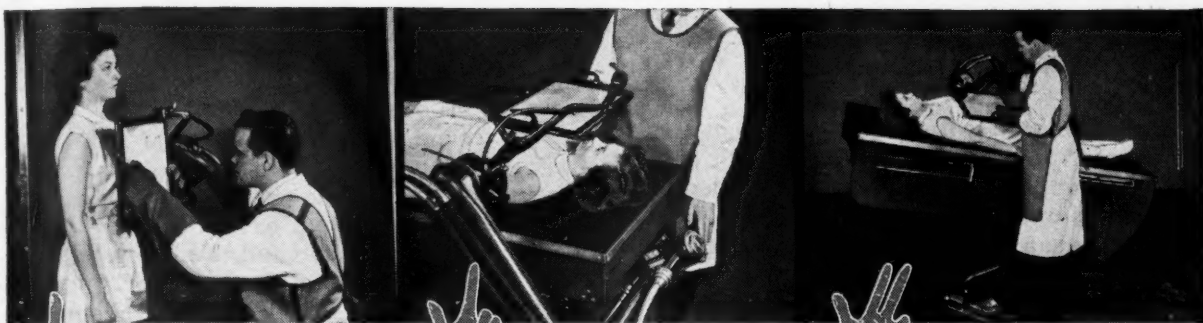
Recently, the mental institutions of the State of Michigan announced salaries of \$5,808.00 for the first year psychiatric resident. Salaries for interns in accredited hospitals also are increasing, with \$3,600.00 a year and full maintenance no longer a rarity.


The primary purpose of intern-resident training is to prepare young doctors to render better service to the public, as practicing physicians. It must be basically an educational experience. Therefore, proper training programs combine the vocational part of patient care with adequate supervision and instruction by staff men selected for soundness of medical knowledge and willingness and ability to teach. It does not consist of just letting the intern or resident tag along with the staff men. Neither does it mean that a series of textbook-rehash lectures organized for the edification of the young doctors will convert a vocational program into an educational experience. Interns and residents are more familiar with the context of such lectures than we are. The very best of teaching is done at the bedside by the qualified clinician. This is always a time-consuming and laborious project when done right, and when so done, superior care is the result.


In contrast, some hospital staffs still believe the primary responsibility of the intern and resident is the care of the patient. The duties outlined are to keep up the records required by accrediting agencies and to function generally as a medical houseboy. This school of thought fights off any attempt to balance the vocational with educational opportunities, by labeling anything beyond manual training as "spoon feeding." Whatever education takes place under such a philosophy is minimal, incidental and accidental.


We have no objection to the purely apprenticeship concept, if so advertised. In fact, we admire

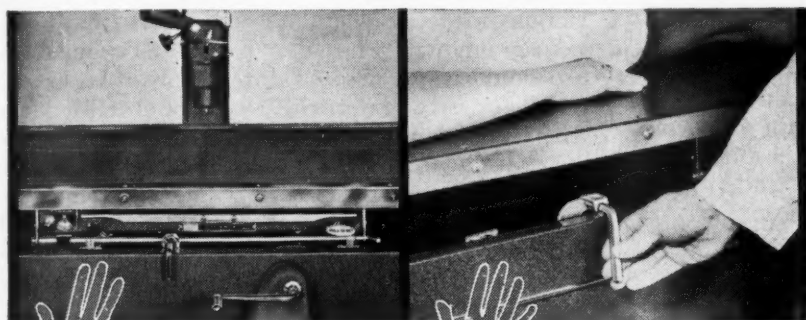
(Continued on Page 680)





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JUNE, 1952

Say you saw it in the *Journal of the Michigan State Medical Society*

679

TRAINING OR EDUCATION?

(Continued from Page 678)

a staff that recognizes its lack of competent teachers, makes no pretense of carrying out an educational program, and hires interns and residents for the specific purpose of supplying technical help to provide good care for patients. What we object to is the misrepresentation and the low wages paid for such highly technical and important services by hospitals that palm off a vocational program under the guise of an educational program.

Usually the stipend is in direct proportion to the vocational demands of the staff, so the higher the pay the lower the educational opportunities. So, we are justified in assuming that high salaries are a tacit admission of a manual training program—or the hiring of interns to take care of patients without adequate teaching supervision.

And, isn't it too bad that the Council on Education and Hospitals of the A.M.A. hasn't the courage to differentiate the two types of hospitals—the vocational and the educational—so students may know!—FRANK A. WEISER, in *Detroit Medical News*, April 28, 1952.

FORMULA FOR FREEDOM

Perhaps one of the most significant projects to be undertaken by a medical organization has been launched by the Michigan State Medical Society in its "Formula For Freedom." A specific, well-thought-out activity around which a complete public relations program can be built, "Formula For Freedom" is based on the hypothesis that no force or subterfuge can take freedom away if Americans understand and appreciate it and prepare themselves to exercise properly their powers and privileges. Emphasizing three elements, "know yourself," "know how to live," and "know your government," the Michigan plan places responsibility on the shoulders of the individual. By helping people to become self-reliant, the program will fight the increasing dependence of the individual on his government which underlies any trend toward socialism.

Although envisioning the co-operation of other professions and businesses, each group translating the formula into its own terms, the Michigan doctors are setting out to apply the "Formula for Freedom" particularly in the area of health. They expect first to distribute a personal appraisal form which will help the person filling it out to know himself better. Space will be allowed for health, social-religious, economic, and legal appraisals, and the forms will be distributed through doctors, lawyers, bankers, churches, insurance agents, service clubs, schools, and unions to an estimated 2,000,000 people. The health appraisal will recommend a comprehensive physical examination which the doctors plan to place within the financial reach of

everyone. After taking an inventory, the doctors hope, a person will know better how to improve himself and should feel that he has a greater control over his own destiny.

The second step is to get across some of the basic socio-economic facts with the assumption that the more a person knows about such things the more competent he will be in coping with them. Newspaper stories, radio and television shows, motion pictures, and health education classes in Michigan already make available information about medicine and health with doses of socio-economic material interspersed.

Finally, the Michigan medical profession seeks to interest citizens in good government, pointing out that citizens should learn what candidates for public office stand for and should vote their convictions in every election.

True enough, the idea behind "Formula For Freedom" is not new. The medical profession has stood for free enterprise, individual effort, and self-reliance and has urged a program to "inform the public" for a long time. Nevertheless, the Michigan formula has a new twist that makes it basic and apparently workable. It will be worth watching and perhaps worth adopting in Texas.—Editorial, *The Texas State Journal of Medicine*, April, 1952.

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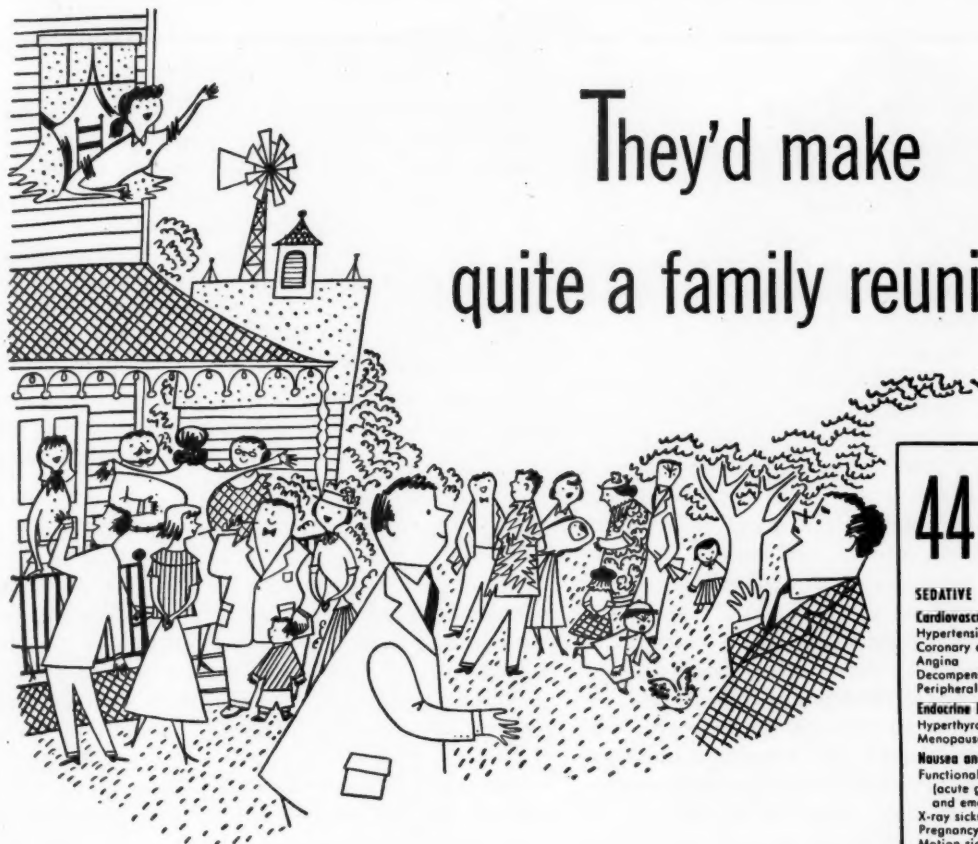
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and emotional)

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Tetanus
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Federal Medicine

THE SHERMAN ANTITRUST LAW

On October 18, 1948, the Federal Government filed suit in the District Court in Oregon against the Oregon State Medical Society, the Oregon Physicians Service, eight County Medical Societies, and eight physicians in Oregon, alleging that they are in restraint of the development of prepayment medical care service in Oregon and surrounding states.

The District Judge after hearing the Government's case ordered a verdict of not proven, without hearing the defense. The Government appealed. The case has been proceeding.

On April 28, 1952, the Supreme Court rendered a final decision. It decided, 7 to 1, that the Federal Government had failed to prove its charges of antitrust law violation by a nonprofit medical and hospital insurance program sponsored by the Oregon Medical Society.

The ruling was a blow to the Justice Department, which has been investigating similar plans operated by doctors' groups in nearly a dozen other states.

The American Medical Association had assailed the Government's moves as an attempt to "terrorize" the medical profession and impose the Truman Administration's plan for compulsory Government health insurance.

We published a complete transcript of the case as first presented in the District Court, because we believed then, and now, that every attempt will be made to discourage the doctors and hospitals in their effort to maintain a free and independent practice of medicine. The Government has been stymied in its attempt through the courts to discredit medicine, but is constantly nibbling off a small item here and there, and someday we may find the core only remaining, and that poor picking. Mr. Ewing's latest bid for the hospitalization of persons over sixty-five is a part of the planned economy.

OSCAR EWING'S LOGIC AGAIN

In a press release covering the annual report of the U. S. Public Health Service for 1951, Federal Security Administrator Ewing preached the same old gospel: "the year's end found 40,000,000 Americans still without the protection of full-time local health services."

"Only half of the 3,070 counties of the United States are served by public health departments," the news release said.

For propaganda purposes, Oscar has a habit of tossing figures around with complete abandon. Sometimes, however, he confuses an issue by contradicting his own figures. He has used the 40,000,000 figure time after time. Yet he had this to say when he testified on local public health units at hearings before the House Committee on Interstate and Foreign Commerce on May 8, 1951:

"... the 40,000,000 figure was geared to the fiscal year 1949, and was based on 1940 population figures adjusted to 1949 by the Census Bureau on an estimate basis. Since then, new and accurate population figures

have become available as a result of the 1950 decennial census, and we have just completed—within the last two or three weeks—a recomputation of these figures. The recomputation shows that the population served by the 1,301 full-time health units—serving 1,734 counties and 268 cities—is approximately 119,000,000, leaving about 31,000,000—instead of 40,000,000—not served by full-time units."

This was his testimony May 8, 1951. But in April, 1952, he was still using the 40,000,000 figure!

Another interesting fact is that while the press release mentioned 40,000,000, no reference was made to this figure in the annual report itself.—AMA Secretary's Letter, April 14, 1952.

PHYSICIANS IN SERVICE

Army is calling up 232 physicians from its reserves for duty beginning in July. Dentists, called at the same time, will come from Priority II for the first time because all Priority I dentists available have been called. . . . One hundred and forty-six senior medical students have been chosen for the Army internship program beginning this July 1.

Selective Service will begin re-examining the status of some 230,000 draft-eligible students this spring as colleges finish out the academic year.

DICKINSON TESTIFIES BEFORE HEALTH COMMISSION

Testifying before the President's Commission on the Health Needs of the Nation in Washington, Frank G. Dickinson, Ph.D., director of the Bureau of Medical Economic Research of the AMA, said that "there has not been to date a realistic study which supports any valid claim that a national doctor shortage is pending."

Dr. Dickinson brought out some good points. He said that "since people need everything, it can be safely assumed that there are unmet needs for medical services, legal services, dental services, Grade A milk, shoes, and any other goods or services which sell for a price. Since all needs are relative, it follows that all unmet needs are relative. Any approach to the study of regionalization will fail at the start if it is based upon the notion that unmet needs are absolute."

Dr. Dickinson pointed out that in recent years two estimates of the doctor shortage for 1960 have been made by the federal government.

"Both of these attempts," he said, "assumed a national shortage rather than bothering to prove a national shortage."

He said further that many factors have been ignored in the two studies for making a reasonable estimate of the surplus or deficit in the 1960 supply of physicians.

"What do physicians do for people? What would more physicians do for people?"

(Continued on Page 684)

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JUNE, 1952

Say you saw it in the *Journal of the Michigan State Medical Society*

683

DICKINSON TESTIFIES BEFORE HEALTH COMMISSION

(Continued from Page 682)

"The median age of the dying has jumped from age 30 in 1900 to age 67. Volumes are being turned out currently on the social and medical care of the aged. Although a physician must always try as hard to prolong the life of an 80-year-old man as he would to prolong the life of a 10-year-old boy, the formulation of national policy on the need for physicians must seriously and sympathetically consider the increasing number and percentage of older people—products of medical progress."

FEDERAL LEGISLATION

Bills for Hospitalization-at-Age-65.—S-3001 and H.R. 7484, identical bills introduced by Senator Murray and Representative Dingell to authorize establishment of a system of government-paid hospitalization for everyone eligible for social security benefits. Eligibles would include persons sixty-five and over who are covered by social security and their dependents as well as the survivors of deceased persons so insured. Hospital benefits would be limited to sixty days in any one calendar year.

Some of the provisions: 1. Beneficiaries would be eligible for drugs, services and appliances "customarily furnished by such hospital to its bed patients," but tuberculosis or mental hospitals "or any hospital or institution which furnished primarily domiciliary or nursing care" could not participate in the program. 2. A physician would have to determine that hospitalization was required. 3. Although costs would be paid out of the Social Security Trust Fund, state departments of health would handle details. The states could, if they so decided, turn administration over to Blue Cross or other non-profit insurance organizations.

In a statement, Senator Murray and Rep. Dingell said about seven million persons would be eligible. They estimated the cost at \$200 million annually.

Extent of benefits—Bed, board, nursing, laboratory, ambulance, operating room, and usual drugs and appliances when hospitalized.

Exclusions—Surgery, domiciliary care, hospitalization for tuberculosis and mental conditions.

Maximum hospitalization annually—Sixty days.

Number of persons eligible—7,100,000 (FSA estimate).

Certification for benefits—By individual's attending physician.

Control of program—The Administrator of the Federal Security Agency would prescribe and promulgate rules and regulations for the conduct of the program. A state would merely act as the agent of the Administrator in carrying out details, functioning through its designated health agency. In the event a state refuses to accept the agency agreement the FSA Administrator would operate the program within such state.

Advisory Committee—Federal Hospital Council, presently functioning under Hill-Burton Act.

Role of private insurance plans—States or the Federal Security Administrator may utilize "the services of private nonprofit organizations" in dealing with hospitals.

Cost of program—Between \$191 and \$235 million annually at the outset, according to FSA estimates. Basis is \$15 per day hospital cost multiplied by approximately two days hospitalization annually per person, multiplied by 7.1 million eligibles.

Financing—Financed entirely by the federal government from the Social Security Trust Fund. No financial contribution would be required from states.

Social Security Amendments—H.R. 7549 by Mr. Kean, of New Jersey, April 23, proposes to extend and improve the Old-Age and Survivors Insurance System, to prevent loss of benefit rights in the event of disability, to provide for rehabilitation, and for other purposes. Referred to the Committee on Ways and Means.

Comment.—Bill seeks to: (1) increase monthly benefits approximately 10 per cent; (2) extend coverage to approximately 5 million additional persons, including 3.5 million agricultural operators, 450 thousand agricultural workers, 500 thousand professional persons (including physicians), 115 thousand domestics, and several hundred thousand casual workers; and (3) provide rehabilitation services and insurance preservation rights for disabled persons.

The bill would remove the exclusion from coverage in the present law of physicians, lawyers, dentists, accountants, architects, engineers, funeral directors, etc.

Rehabilitation services presently available under the federal Vocational Rehabilitation Act, including medical care, hospitalization, appliances, etc., would be rendered through state agencies to disabled persons who are expected to be disabled throughout a six-month waiting period or longer and to totally and permanently disabled persons so that workers might be returned to gainful employment. The entire cost of such rehabilitation services would be borne by the Social Security Trust Fund. Presently federal funds are being expended under the Vocational Rehabilitation Act at the rate of 21½ million dollars annually. During the period of disability, insurance rights for workers would be preserved so that in computing old age benefits later, the period of disability would not be included in determining an average monthly wage.

The Administrator of the Federal Security Agency would determine whether a claimant is permanently and totally disabled, or is likely to be, unless rehabilitated. The Administrator would arrange for medical examinations and re-examinations of disability claimants. Examinations would be performed in existing facilities of the federal government, if available, and by impartial private physicians, clinics, hospitals or other medical facilities designated by the Administrator. The Administrator would be authorized to secure the co-operation of public agencies and private medical, dental, hospital, nursing, health, educational, social, and welfare groups for advice and service in carrying out the vocational rehabilitation and examination sections of the bill.

No increase in payroll deduction for social security insurance is provided in the bill.

House Passes Bill Favoring Physicians and Other Skilled Immigrant Applicants.—The House, on April 25, passed a bill drastically revising the Nation's immigra-

(Continued on Page 714)

The JOURNAL

of the Michigan State Medical Society

ISSUED MONTHLY UNDER THE DIRECTION OF THE COUNCIL

VOLUME 51

JUNE, 1952

NUMBER 6

Principles of Good Clinical Anesthesia

By E. M. Papper, M.D.
New York, New York

THERE IS NO physician who favors "bad" clinical anesthesia. Almost all of us, in keeping with our human heritage, prefer to be aligned on the side of the righteous and the "good." It could be pleasant, therefore, to describe the elements of good clinical anesthesia as facts and know that we would nod our collective heads in agreement or boredom and feel that an unimportant problem has been settled. To do so would be smug and dishonest.

It appears more useful and valuable to develop a point of view about thinking and practice in anesthesiology than it would to confine this discussion to current methods alone. The tacit and sometimes open implication that there are "ideal" ways to anesthetize patients for surgical operations is misleading. One cannot quarrel with the desire to establish secure and finite goals directed toward the safe management of anesthetized patients. But much issue can be taken with the reluctance to accept the fact that the production of surgical anesthesia bears a physiological price tag in exchange for the benefits of pain relief and adequate operating conditions for the surgeon. We will be concerned with some of the factors which minimize that price tag. They consist in general of the technical skill of the ad-

ministration of potent anesthetic drugs and the intellectual aspects of clinical judgment and scientific knowledge which are essential guides to the practicing hand.

The technical aspects of anesthesiology have occupied a rather curious position in the thinking of specialists in this field, as well as in the minds of physicians whose interests are in other branches of medicine and surgery. On the one hand, there are those who cherish the performance of a given anesthetic maneuver with technical finesse as the sole criterion of good clinical anesthesia. There are others who have looked upon the technical nature of anesthesia very much like the citizens of classical Greece and Rome looked upon the artisan and craftsman. This feeling is one of contempt for manual labor and for the exercise of purely technical skill. The apparently simple maneuvers in the administration of many surgical anesthetics have not always been appreciated as exercises worthy of the dignity of the thinking physician. A second aspect of good clinical anesthesiology is concerned with judgment and scientific knowledge. It involves, among other things, the necessity of understanding the impact of anesthetic agents and methods upon physiological activity. It appears sensible to believe that the fruitful application of anesthesiology to the care of the surgical sick is the development of both the technical and the intellectual aspects of the specialty. It is not enough to apply a technical maneuver without mature judgment and understanding of what is implied and what the result of that technical maneuver may be. It is also not sufficient to understand the effects of anesthetic agents and drugs without competent skill in using them for the surgical patient.

It will serve our purpose to consider some of the aspects of clinical anesthesia in terms of the specific problems that arise from the effects of

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Presented at the eighty-sixth Annual Session of the Michigan State Medical Society, Grand Rapids, September 27, 1951.

JUNE, 1952

689

anesthetic agents and methods upon surgical patients.

It is certainly not a new thought to suggest that the beginnings of good clinical anesthesia are concerned with the skills of the anesthesiologist. It is also not new to point out that the best anesthesiologist is first a good physician before he is a competent specialist. Since the planning of anesthesia starts with the understanding of the nature of the surgical operation, the anesthesiologist must have a clear picture of the plan of attack of the surgical team in the specific problem at hand.

Secondly, consideration is given to the deviations from normal physiological activity of the patient who is to be subjected to an operation. The anesthesiologist must know as much as can be known about the health and organ function of the patient. He is also responsible for a thorough knowledge of the effects of anesthetic drugs which will be administered.

Before selecting the anesthetic agent or method, much must be learned about the patient himself as a person. This type of information can be gathered, not only from the history acquired by the patient's physician or surgeon, but by a sensible and searching interview prior to the administration of anesthesia. Frequently a surgical patient is more fearful and more concerned about his anesthetic experience than he is about the operation itself. By the time he is admitted to the hospital, the patient usually accepts the need for the removal of a pathological organ or for the alterations of physiological activity by surgical attack. It is usually within the hospital that he begins to consider seriously what will happen to him in the process of securing pain relief, loss of consciousness or other forms of anesthesia. It has become evident that such disturbing thoughts occur to surgical patients and that a good answer for these anxieties is the provision of information with sympathetic understanding about the anesthetic experience immediately ahead.

It has been poor practice, in our experience, to attempt to deceive the patient with the simple statement that all will be well. Such flamboyant optimism may be satisfactory for some patients, but by and large, most expect and deserve a more effective and a closer relationship with the anesthesiologist. On the basis, then, of the evaluation of the surgical requirements, the medical situation, and the personality of the patient, it is possible to select a method of anesthesia in most

instances that will provide good working conditions for the surgeon, a minimum of harm to the patient, and on the whole a not unpleasant experience for the most important member of the operating team, the patient.

Although it is manifestly impossible to blueprint a good method of clinical anesthesia for all circumstances, it is feasible to consider in the actual administration of anesthesia the twin aspects of technical proficiency and clinical and scientific judgment in terms of a few of the common problems encountered in the operating room.

The intact function of respiration is a basic axiom in the performance of all good clinical anesthesia. The maintenance of normal respiration in the surgical patient is a primary goal. The reasons must be obvious. This is the only method available for the oxygenation of the tissues of the body and for the elimination of carbon dioxide. With inhalation anesthesia, it is the portal of entry for the agent which is to provide comfort for the patient and a satisfactory working arrangement for the surgeon. Unfortunately, almost all anesthetic agents produce changes in respiration. Many are central depressants, which can, if manipulated either improperly or in a circumstance not ideally suited to their use, produce harmful changes associated with either deficient oxygenation, carbon dioxide accumulation or both. These effects are observed not only with inhalation anesthesia, but also with intravenous anesthesia, with the use of premedicant drugs, with spinal anesthesia and, in certain circumstances, with other forms of regional or local anesthesia. The anesthesiologist is concerned with maintaining adequate oxygenation and eliminating carbon dioxide. The first of these requirements is apparent and needs no further elaboration. The role of carbon dioxide accumulation bears further comment. It has been well known that retention of carbon dioxide is a possible cause of convulsions, hypertension and tachycardia.⁵ In recent studies the role of carbon dioxide has been appreciated further. In an incredibly short few minutes the deficient elimination of carbon dioxide can produce an acidosis of great enough magnitude to overcome the buffering effects of the blood and plasma to the point of producing significant reduction in arterial blood pH.² The full implications of such an acidosis are not known at the present time, but there is evidence to suggest that this is a possible underlying basis for the pro-

duction of circulatory catastrophe, renal damage and even cessation of the heart beat. It might appear that the problem is relatively easy to solve, but such is not the case. With the aid of assisted breathing techniques, the achievement of adequate oxygenation is not so difficult as the efficient elimination of carbon dioxide. Assisted or controlled breathing techniques may also precipitate undesirable circulatory effects in the form of reduction of cardiac output.³ The competent anesthesiologist who is skillful technically and proficient in judgment and knowledge may avoid a good many of the situations which lead to respiratory acidosis and deficient oxygenation, but not all. It is in this sphere that further investigation is required to improve the management of poor risk patients beyond the best of skill and knowledge now available.

It is impossible to administer any form of clinical anesthesia that does not have the potentiality of a deleterious influence upon respiration. The good clinical anesthesiologist can minimize both the frequency and the severity of these changes.

The administration of anesthesia is intimately concerned with effects upon the circulation. These consist of the function of the heart with respect to mechanical activity and rhythmicity. There are also alterations in the maintenance of normal arterial pressure and normal perfusion of blood to the various organs, particularly the brain, the heart and the kidneys. There is much knowledge and also many gaps in our understanding of the circulatory effects of anesthetic agents and methods.

There is almost no anesthetic agent that under certain circumstances will not effect some changes in the circulation. Most of the potent inhalant agents, for example, cause an initial increase in cardiac output. Spinal anesthesia produces a reduction in cardiac output. We do not understand enough at the present time to know whether or not these changes are desirable. Our position is one of gathering the facts and trying to interpret them in the light of practical experience. It appears reasonable, however, to strive for as little change in cardiac activity from the normal as is possible. The maintenance of normality appears to be concerned, in part, with a gradual presentation of an anesthetic burden to the heart in preference to sudden changes in depths of

anesthesia or flooding of the coronary circulation with anesthetic drugs.

Although it is true that irregularities of rate and rhythm are more commonly associated with halogenated drugs and with cyclopropane than with others, it is still possible to produce arrhythmias with any anesthetic agent if meticulous care is not exercised for the preservation of adequate oxygenation and freedom from respiratory acidosis. The alterations in arterial pressure are found in either direction and with all the drugs. Unfortunately, much remains to be learned about the nature of the circulatory responses to anesthesia. However, much can be done in the administration of anesthesia with the knowledge now available. The treatment of changes in arterial pressure requires some understanding of the mechanisms involved. Falls in blood pressure may be concerned with blood loss or shock or trauma. These must be corrected by the anesthesiologist with whole blood or with plasma expanders. Changes in arterial tension are frequently associated with visceral manipulations. These can be corrected by blocking the nervous pathways which mediate such "traction reflexes" or by the administration of suitable drugs which will elevate peripheral resistance in the vascular bed. It is a common clinical error to inject a compound like epinephrine or nor-epinephrine to increase peripheral resistance and raise arterial pressure in the presence of anesthetic agents like cyclopropane. This combination can produce a serious cardiac arrhythmia, even to the point of ventricular fibrillation. Neosynephrine and ephedrine are safer and equally effective.

Another problem of importance in the provision of good clinical anesthesia is the maintenance of the function of vital but "silent" organs. Renal function is perhaps of primary consideration in this connection. The renal circulation carries approximately one-third of the cardiac output. Furthermore, the kidney is intimately concerned with the maintenance of normal acid base and fluid balance. Despite these extensive activities, the kidney does not provide signs or symptoms of abnormal behavior in a gross sense during a surgical procedure. It is of the greatest importance, therefore, to understand that anesthetic agents and methods have a significant effect upon renal activity both in its filtration and reabsorption functions and in its role in the circulation.

Most anesthetic agents that produce loss of consciousness, however administered, have a profound and sudden effect upon renal activity. It has been shown that the role of the kidney as a circulatory organ is considerably impaired.⁴ A significant reduction in blood flow occurs to the kidney during all forms of general anesthesia. The kidney's ability to filter and its normal pattern of reabsorption are also considerably changed under the influence of anesthetic agents. Unfortunately, this response of the kidney appears to be a stereotyped one to most anesthetic agents and methods. The influence these effects produce on subsequent satisfactory recovery from anesthesia and operation must be considerable. The conduct of good clinical anesthesia involves the knowledge that such changes do occur and the avoidance of technical errors which may produce a further burden upon a functionally damaged kidney in the presence of surgical anesthesia.

These illustrations of physiological changes which must be considered in the carrying out of good clinical anesthesia are described for one major purpose. It is necessary to realize that such changes in physiological activity do occur, that they may be of great magnitude and that present knowledge directed toward their control is limited. It is necessary, in order to reduce these physiological penalties, that the administration of anesthesia include technical skill and the best possible understanding of the effects produced upon body function. The requirement, therefore, is that the skillful anesthesiologist and his associates have a healthy respect for the work of the hands and an appreciation of the work of the brain. Improvements in good clinical anesthesia, as in other branches of medicine, will come from the laboratories and from the careful and intelligent gathering of clinical experience which can be transferred to problems in the future. These aims may be summarized in the same manner as the goal of any science. Bacon put it this way: "... we seek the history of nature constrained and vexed, that is to say of nature thrust from her original state mastered and modified by the art and agency of man."¹ This is the future of anesthesiology as well as the other sciences. It is the wisdom that is concerned with the mastery of the effects of drugs upon the body of man. It is not pessimistic to look upon this development as one that can never achieve complete control and complete understanding.

References

1. Bacon, Francis: *Distributio Opus*.
2. Beecher, H. K., and Murphy, A. J.: Acidosis during thoracic surgery. *J. Thoracic Surg.*, 19:50, 1950.
3. Cournand, A.; Motley, H. L.; Werko, L., and Richards, D. W.: Physiological studies of the effects of intermittent positive pressure breathing on cardiac output in man. *Am. J. Physiol.*, 152:162, 1948.
4. Habif, D. V.; Papper, E. M.; Fitzpatrick, H. F.; Lowrance, P.; Smythe, C. McC., and Bradley, S. E.: Renal and hepatic blood flow, glomerular filtration rate, and urinary output of electrolytes during cyclopropane, ether and thiopental anesthesia, operation and immediate postoperative period. *Surgery*, 30:241, 1951.
5. Seevers, M. H.: Convulsion during anesthesia; experimental analysis of the role of hyperthermia and acidosis. *Anesthesiology*, 1:56, 1940.

MSMS

FEDERAL, STATE MEDICAL STOCKPILES MAY EXCEED \$80 MILLION BY MID-YEAR

Latest Civil Defense Administration figures indicate total federal and state stockpiles of medical supplies on hand or on order by July 1 may amount to \$80.5 million. Of this, CDA has committed nearly all of the \$50 million voted by Congress for exclusively *federal regional stockpiles*. In addition, CDA already has given states \$10.5 million which they in turn have matched on a 50-50 basis for *local supplies*. CDA has on hand about \$9.5 million from the original matching fund appropriation which Congress has said may be used for the *federal stockpile*, provided it's committed by June 30.

CDA explains it has the \$9.5 million left over because (a) five states containing critical target areas are not yet participating in the federal-state program, (b) market prices of some supplies have dropped, effecting savings, and (c) additional savings were achieved through simplification of specifications of some items. The states that did not join in the program by the March 15 deadline are Alabama, Georgia, Texas, Louisiana and Illinois.

Civil Defense Administrator Millard Caldwell, meanwhile, had informed Chairman Brien McMahon of Joint Committee on Atomic Energy that medical stockpiling is "unsatisfactory both in volume and quantities of supplies available." Caldwell estimates funds voted by Congress so far would provide enough supplies for only one week of emergency care for 2 million atomic bomb casualties.

For its fiscal 1953 program, CDA is asking Congress for \$193 million for *federal medical stockpiling*. No matching funds for *local stockpiling* are requested for next year.

JMSMS

Then and Now

By Neal R. Moore, M.D.

Bay City, Michigan

TONIGHT marks the completion of the officially designated year of activity of our society. There is a custom among the Chinese, centuries old, that directs the head of the family to make periodic pilgrimages to the tomb of his forefathers; there, to sit for a time, in reflection, analyzing his accomplishments of the recent past and weighing the good thereof against the evil, contemplating the future and, in communion with the spirits of his ancestors praying for a continuance of their faith in him, and pledging to them renewed effort toward the doing of good and to the advancement of his ideals. It is in this spirit that I ask you to join me tonight—in reviewing the advances of the medical profession in the past fifty years, in bringing into focus for a moment of consideration some of the issues at hand that are presently unsolved, and to give thought to certain positive measures that will assure to us continuation of the present high standards of the practice of medicine.

The present-day physician, the doctor of medicine who has earned his income in 1951, lives and practices in a relative paradise. This paradise is of his own making, created by him with the aid of those organizations whose continued existence is dependent, wholly or in large part on the fact that he is a practicing physician. It is through the efforts of the medical profession and its allied services that the armamentarium of today's doctor is so vastly superior to that available to the man of medicine of even a half century ago. This fact I would emphasize. To better appreciate these advances, let us consider for a moment a few of the principles of practice, the procedures, and the technological facilities extant in the year 1901, and compare them with those existing today.

Pneumonia

In that earlier year, in the field of internal medicine the treatment of pneumonia was rational but entirely supportive. The patient was treated symptomatically until either his own body re-

sistance overcame the infection or, the severity of it overwhelmed him and he died, usually in dramatic fashion. The mortality rate was appalling. The day of specific pharmacals had not yet dawned. The attending physician was saddened by the knowledge that the measures at hand to treat this disease were so pitifully few and inadequate.

Typhoid

Typhoid fever was rampant. Its incidence in sporadic and endemic proportions was accepted as a matter of course, inevitable. Each spring thaw meant that the children could be cut out of their winter underwear, that mother could think of planting the garden, and that father could pull on his short boots and begin plowing his untilled and untiled acres. But this season of the year also brought the dread of typhoid fever, of cholera morbus, of ptomaine poisoning, of milk fever and those other infections caused by contamination of the water, milk, and food supplies. The spring and summer were times of concern, or of terror depending on the incidence of these diseases. All hoped to escape the dread maladies but no one knew what measures to take to avoid them. Ignorance of even the simplest principles of water decontamination and food preservation lay at the bottom of this sad state of affairs and, even if there had been enlightenment in these matters, proper facilities to safeguard public health were not then available.

Diabetes

The mild diabetetic of that time lived in apprehension. His prayer was that his affliction would not increase in severity since the only known measures of treatment were "alkalinization" and an unstandardized dietary regime. Scientific dietary control and insulin were not to appear upon the scene until two more decades had passed. The adult who suffered with severe diabetes could but resign himself to his certain fate and to hope that his tenure of life would be a bit longer than in the average case. Establishment of the diagnosis of diabetes in the child or young adult was accepted as a sentence of death.

Surgery

In the field of surgery, preoperative care, support of the patient during operation, and post-operative care were such that we of today would

The President's Address delivered at the annual meeting of The Bay County Medical Society, December 12, 1951.

consider them primitive, indeed. The average patient who faced operation first saw his lawyer to have his will drawn up, next saw his priest to have his spiritual affairs set in order and, then went to the hospital, resigned but hopeful. He frequently entered the institution on the morning of operation and, after having been relieved of his clothing was placed on a wheeled cart and taken, immediately, to surgery. And, so arrived, was, without further formality other than casual preparation of the operative site, started on his way to temporary oblivion. Open ether was the anaesthetic of choice with chloroform being administered if "piles" were to be removed with cautery or if an abscess cavity were to be "burned out." Other anaesthetic agents were either unknown or had had such limited use that they were not then accepted as being safe or reliable. The anesthetist would have viewed the standard gas inhalation apparatus of today with as much curiosity as would have any lay visitor to the surgery.

The anesthetist sat at the patient's head, in his street clothes, minus his coat and, sometimes, with his outer shirt removed, sans cap and mask. Traffic in the operating room was free and, usually, abundant. Referring physicians frequently wandered in, dressed in street attire, to either discuss with the surgeon some point regarding a case in which they were interested or, merely, to watch him operate. Such a visitor to that arena would have been mortally insulted if asked to don cap, mask, and gown before entering.

It was under these conditions, then, that the surgeon did his work. He operated swiftly and deftly—necessarily so because there was nothing available to support the patient during the operation. Intravenous fluids, immediate transfusions, and currently used drugs were unknown to him. His technique was limited by the then unavailability of electrocautery and electrosurgery, by poor lighting, by lack of suction and, in many instances, by the enforced use of primitive instruments. Surely, it is a tribute to the surgeon of that day that his work was of such high quality and that his mortality rate was as low as it was.

On completion of the operation the patient was taken directly to his room and placed in a preheated bed, the foot of which had been elevated in correct anticipation of his state of shock at that moment. Postoperative treatment was mainly anticipatory. Loss of fluids incurred during operation could not be combated until the patient had

regained consciousness and was again able to swallow since, as has been stated, there were no intravenous fluids to maintain or to restore fluid balance. An additional three years were to pass before the patient was able to view the propped crutch at the foot of his bed that supported the Murphy drip container. On regaining consciousness, the pitiful cries for water were answered by intermittent wetting of the lips with ice water, interspersed with occasional sips of chilled brandy. And, frequently, when the abdomen became distended in the days following surgery, turpentine stupes were applied—that is, of course, if the site of operation did not interfere. The rectal tube was used, freely. The patient did not know the benefits of or enjoy the relief afforded by the Levine and Miller-Abbott tubes and the Wangensteen apparatus. Such was the accepted and standard regime of treatment of the postoperative patient in the year 1901. Incidence of postoperative peritonitis was high. Treatment of this complication was simple since antibiotics were unknown and other measures in common use today had not then been developed. It consisted of elevation of the head of the bed that there might be dependent drainage into the pelvis. Beyond this point treatment was limited to the fervent prayers of the relatives and of the surgeon. Mortality in postoperative peritonitis was about 60 per cent.

Gynecological operations were infrequently done, the doughnut pessary being relied on to keep the sufferer on her feet. The accepted principle seemed to be that it was far better to let mother live in a state of half invalidism than to expose her to the likelihood of prolonged morbidity or, even, the possibility of fatality, the two eventualities that all too frequently followed such elective procedures. The incidence of postoperative sloughing of perineal tissue was high and this was a deterring factor in performing operations on the female perineum.

Medical Research

Medical research was at a low ebb—not because of paucity of constructive thought but because the many factors named earlier negated efforts in this branch of medicine. The chief ones retarding progress in this field were inability to adequately combat shock and to control postoperative infection, lack of knowledge of proper methods of sterilization of milk, decontamination of water and preservation of foodstuffs, and unavailability of ade-

quate facilities for this type of endeavor. This led to a continuing sense of discouragement and futility. Many of the procedures and measures, standard today were brilliantly conceived before the turn of the century, but their practical application perforce awaited refinements that we accept as commonplace. Surmounting these major obstacles has resulted in the development of, among other things, the entire field of thoracic surgery, modern genito-urinary surgery, much of orthopedic surgery, total gastric resection, the combined abdominal-perineal operation, brain surgery, operative procedures in which metallic or other foreign material is placed in the patient's body, there to be retained permanently, and skin grafting in its present state of refinement.

Obstetrics

It appears that only in the field of obstetrics can a favorable comparison be made. The principles and practice accepted as standard in that earlier year are generally those prevailing today. Recognition of puerperal sepsis as an infection, an exact description of its clinical characteristics and mode of transmission, and an outline of measures necessary to prevent its occurrence and to control its course had been given to the profession in the nineteenth century by Doctor Oliver Wendell Holmes. And those principles that he had so clearly enunciated had been common practice in that specialty for many years. Obstetrical procedures which are routine now were likewise in common use in 1901. And the various forms of the obstetrical forceps were employed then, as now.

Economic Status

A brief review of the contrasting economic states of that day and this may be in order. At the dawn of the twentieth century, the annual cash income of the average physician was in the neighborhood of \$3,500.00. And, while the purchasing power of the dollar was higher then, income was disproportionately less than that which we enjoy. The above-stated income did not truly represent the doctor's total income since he frequently accepted payment in kind for his services—hay and oats for the horse, cords of slabwood, garden produce and potatoes, a dressed hog or a quarter of beef, or even, services. This method of payment was considered proper because of the very real dollar shortage.

Also, it must be remembered that virtual guarantee of at least part-payment for services rendered was unheard of. A prepayment health insurance plan existed then, only in the mind of the visionary. This, to us, primitive economic state was not limited to the medical profession but involved all fields of human activity.

An additional adverse factor in the economic picture was the wholly inadequate transportation system. Highways that were poor, at best and nearly always impassable in the winter and spring months and the slow speed of the average "hay burner" reduced the doctor's working time per day, shamefully. Further waste of time and effort were occasioned by a poorly operating and sparsely distributed telephone network. One telephone per two city blocks and one telephone per square mile in the rural areas were the ratios of that time. The speaker can attest to the reality of the difficulties of transportation from his own personal experiences, on two occasions having helped unhitch the faithful horse after she had slipped and fallen while pulling a two-wheeled cart through the springtime morass of a country road, in the dead of night and, on three occasions having been unceremoniously dumped from a cutter that overturned in near zero weather on roads that had never seen and would not, for many more years, see a snow plow. May I hasten to state that on none of these occasions was I the physician but was merely the juvenile who accompanied his father, for companionship only. As may well be imagined, these untoward incidents were a bit time-consuming and certainly were not conducive to clear thinking and a pleasant outlook on life.

Who among us would feel at ease or even adequate to face the treatment of patients under these conditions? What man here would have the courage to ride miles to a farm home in a sleigh, there to perform a curettment or, possibly an appendectomy, with the patient lying on a kitchen table; or, to walk a mile or more over impassable roads to that same home to do a version, by lamplight, with only a teakettle of boiled water and Bichloride tablets to safeguard against childbed fever and with a half hysterical husband or a questionably clean neighboring housewife to administer chloroform anaesthesia? Would we be willing to go into practice under such circumstances knowing what we do now? Let us reflect for a moment on the blessings we enjoy today. Also, let us pause in tribute to those hardy souls who lived and prac-

ticed thusly but who were still able to face the future with determination and in the sustained hope of better things to come. Is there not somewhat of a parallel between the hardships endured by these men and those suffered by the apostle Paul, in his travels—"In weariness and in painfulness, in watchings often in hunger and in thirst, in fastings often, in cold and nakedness."

Notwithstanding these real and grave handicaps, a surprisingly high standard of practice was maintained. The reasons for this were twofold, one being the physician's slavish devotion to his patients, regardless of his own comforts or even welfare and the other, an inspiration arising from the conviction that he was standing on the threshold of a new period in the practice of medicine.

Medicine Today

From the above recital, it may be seen that we who are currently practicing medicine are doing so in a comparatively golden era. Let us now ask ourselves how we have arrived at this happy state of affairs, how these improved conditions have been brought about.

Of those factors operating to effect this change, I would name first, the improved economic status of the country, as a whole. This has resulted in the development of valuable technological aids and in vastly improved communications systems and transportation facilities; second, increasing public education, whereby detailed knowledge of medical precepts has been more widely disseminated and, hence better understood and more generally accepted; and, last and most important, that driving force within the medical profession itself that has not only vigorously rejected maintenance of the *status quo* but has inspired, encouraged, and even urged its members to broader and more forward thinking; and has continually goaded its ancillary services to the study of problems that, at first hand appear to have no plausible solution and, later, to demand of those services rational solutions for them.

Organized medicine has provided the individual physician rich opportunities to improve his talents and to advance his medical knowledge through refresher courses, panel discussions, scientific meetings, supervised residencies and other forms of regulated postgraduate training. Organization of the several colleges and of the academies in various specialties has proven a powerful stimulus to deeper broader thinking. The activity of these

groups has resulted in much good through the interchange of progressive thought, the establishment of higher standards of practice and through wider knowledge of detailed phases of a particular specialty, gained by study of particular problems of that specialty by members designated to make such study.

Before passing on to other considerations, I feel a few additional remarks should be made regarding the role that education of the public has played in bringing about the general advancement of medicine. In the preface to his book, "Understandable Psychology," Leland E. Hinsie has pointed out the benefits to be derived from some degree of pre-knowledge by the patient. Quoting from this preface:

"The practice of medicine is the partnership between the person seeking information and the physician, qualified by training and experience, who gives it. Years ago the patient aware only of his distress and having no knowledge of the possible meaning of it, stood by mutely, while the physician examined and treated him. Moreover the former seldom imparted any information about the disease to the patient. While this relation remained thus, neither gained as much as could have come out of the situation had each given freely to the other.

"Today the situation is quite different because the value of co-operation is well established. People know more about medicine in the first place, because much more is known in general, but particularly because what is known is made available to people as facts to be acted upon in the interest of health, not as mere intellectual acquisitions. In the practice of medicine, the patient is the central figure, not only because he or she is ill, but also because he or she is the first one to become aware of the earliest signs of disorder."

The thoughts expressed in the above quotation reveal a healthy attitude toward public enlightenment on the part of the modern practitioner. They also reveal the extent to which the public has become educated in matters medical.

These, then, are the influences that have operated throughout the past fifty years to enable us to enjoy the present excellent state of the practice of medicine. And, for the beneficent effect of these influences we stand eternally grateful.

The presentation just made, within the scope of the limited ability of the speaker to do so has outlined the conditions prevailing in the practice of medicine in the year 1901 and contrasted them with those under which we practice today; and, has given a brief explanation of the forces that

have brought about the significant changes recorded in the profession in the past fifty years.

However, in spite of the excellent facilities we enjoy, the ease and comfort in which we practice and the broadened concepts in force today, let all be sobered by the realization that there is much left undone, that many fields remain unexplored in the profession. Those who have gone before builded well. They opened new vistas to us. They broadened our horizons. Truly, they have given us a noble heritage. It is for us, then to be inspired to continue their search for greater truths. Who can deny the challenge that lies in the unsolved mysteries of malignancies, the virus infections, blood dyscrasias and in the host of other obscure, little understood diseases. Surely, such are an inspiration to forward thinking, to a broader vision, to determination to make some effort toward progress in medicine. A sense of self-assurance and complacency is a harbinger of retrogression, of a state of degeneration. It has been well said that where there is no vision, the people perish.

It is felt that this paper would not be complete or have served its best purpose if it did not bring into the limelight for a moment a few of the vital issues that face us today and for which there have not yet been provided satisfactory solutions. And, to make recommendations for certain positive actions that may lead to further advances in our chosen profession. The unresolved issues I shall name and the recommendations I shall make are based on personal observations, inquiries, and on expressed, unsolicited opinions of many fellow practitioners, both locally and throughout the state. In order of importance I would name first, the patient-doctor relationship; then, the threat of governmental intrusion into those rights and privileges now enjoyed by the doctor of medicine; and, finally, the double standard of the practice of medicine in this state.

Patient-Physician Relationship

In various quarters, some lay and some professional, positive opinions have been expressed concerning the current relationship that exists between the patient and his physician. From these opinions the definite impression is gained that there is a disturbance in that relationship as we have known it for many years. It is felt that this change is not great and certainly not universal, but its occurrence is too widespread to be ignored. The underlying cause of this imbalance is a bit difficult to de-

termine—many factors seem to have had a hand in bringing about the change. Among these are the impact of the recent war on many of us who were exposed to a necessarily socialistic type of practice for from three to five years, an increasing desire to seek further knowledge and training in one specific branch of medicine, rather than to continue on in general practice or, in other words, the growing trend toward specialization, and a certain sense of futility, engendered by the existing chaotic economic state and by a mounting tax rate that threatens to reach confiscatory levels. Which one of these is predominant as a causative factor is immaterial. The fact remains that, in response to the influence of one or more of them the patient, as an entity, has been placed in a shadow; that he is being regarded less as a fellow human being who is agitated in spirit whether he be physically or mentally ill than as a clinical condition; to be treated intelligently and to the full satisfaction of a normal conscience and, then, sent on his way, forgotten. However, the consensus is that this relationship is improving, not degenerating; that the pendulum has passed its extreme and is returning toward normal, and that soon, there will again be the happy blending of "The Old Humanities and The New Science."

Again, quoting from the preface to Dr. Hinsie's book:

"The patient is the central figure in the practice of medicine because he or she constitutes the only reason for the existence of the physician."

It is for us, then to enhance this most human bond between us, the physician on the one hand and that other being, the patient, on the other. We must strive to keep uppermost in our minds an awareness of the real soul agony of the patient during his illness and to instill in him the certain knowledge that we are not only his personal physician but his friend, as well.

Threat of Governmental Intrusion

Little need be said of the seriousness of this menace, of the danger inherent in the continuing and increasing pressure to take away from us the privilege to practice medicine, within the bounds of conscience, unfettered by stifling ukase. Several years ago I was privileged to read a copy of a resolution introduced into the United States Senate by the then senator from Illinois, J. Ham Lewis. The first paragraph proposed that all phy-

sicians in the United States be made federal officers and be placed under direct governmental control. "Thus ended the reading of the word." That was all I could take. Needless to say, that bill was not enacted into law. However, in the ensuing years many resolutions and bills of similar intent—subjugation of the doctor of medicine, have been introduced and all have failed of passage. But who can tell when, by some evil chance one may slip through the legislature and become the law of the land.

I would urge, therefore, that we take a more personal interest in this question. I would urge that it be included in our daily thoughts and be discussed freely and factually with those with whom we converse. It is only by this method, augmented by the concerted efforts of organized medicine that this specter of socialism can be driven into oblivion. We must be unrelenting in our efforts, explaining to all who would listen the deadly significance of this evil plan of compulsory health insurance. For this is the entering wedge of socialism, this the cornerstone of the socialistic state. This is the rock that either we smash or upon which we shall be broken. Ours is the responsibility to stay strong and to lead the fight; if we fail, all is lost. How infinitely better to press the issue with a militant attitude, and to at least hold our own than to be passive and, then, when the deluge will have come to say as did the king in his garden, "God be merciful to me, a fool."

Double Standards of Practice

The third issue I would call to your attention is the double standard of the practice of medicine in the state of Michigan. This is an issue wholly unresolved; an issue that demands prompt decisive action to effect a satisfactory solution. And I urge that appropriate action be taken in the immediate future.

My remarks on this question will be brief and, I trust, to the point. I challenge all within the sound of my voice, or anyone in this state, of good faith and capable of intelligent thought to justify or even rationalize the existence and continued functioning of two separate and distinct boards of licensure, each empowered, in effect, to grant the privilege of practicing medicine and surgery in this state. How ridiculous! How incongruous! What a travesty on common sense and reason! The situation might even be ludicrous, were it not

for the fact that the unsuspecting patient is the victim.

Gentlemen, whosoever undertakes to treat the physical and mental ills of mankind is, in fact, practicing medicine. And the practice of medicine is an indivisible whole, a single entity, incapable of being broken down into parts or phases. It has but a single standard. It is not a set of parallel or collateral practices, and to so regard it means that the patient who is the only excuse for its existence suffers.

Therefore, let me again urge that we abolish the superfluous board that the above truth may be brought into its full realization. With these remarks I close my tenure of office. To those who have served with me, my heartfelt thanks for work well done. To my successor a hearty wish for an even better year than that presently past. My sentiments on stepping down are best expressed in the words of Kipling's "Galley Slave"—

And tonight I leave the galley,
And another takes my place,
There's my name upon the deck beam,
Let it stand a little space.

And tonight I leave the galley,
Shall I curse her service then,
God be thanked, whate'er comes after,
I have lived and toiled with men.



NEW PAMPHLET ON COST OF SICKNESS

To create a better understanding of one of the major causes of patient-doctor misunderstanding—the cost of illness—a new pamphlet has been designed for public distribution. Entitled "Your Money's Worth in Health," the booklet stresses the various aspects of patients' medical bills and the cost of illness in relation to the national income. The pamphlet shows graphically that the cost of illness has not risen as much or as rapidly as other consumer goods. This illustrated eight-page pamphlet soon will be made available to AMA members and medical societies for distribution to the general public.

* * *

AMA EDUCATION FOUNDATION

Dr. Donald G. Anderson, secretary of the council, reports that contributions to the American Medical Education Foundation are gaining in momentum. During 1951, contributions totaling \$745,000 were received from 1,811 individual physicians, thirty-three organizations and thirty-three lay friends of the medical profession.

JMSMS

Vertigo

Diagnosis and Treatment

By J. Lewis Dill, M.D.

Detroit, Michigan

THE TERM "vertigo" may be defined as a subjective sensation of rotational or linear movement or displacement of oneself in relation to environment, or of external objects in relation to the individual. The word "dizziness" has a different meaning for different people, but the sensation can be more correctly described in such terms as "light-headedness, giddiness, faintness, unsteadiness, confusion" or even as "specks before the eyes." The two words "vertigo" and "dizziness" are often used synonymously, but this is of little actual importance when the physician correctly understands and interprets the symptoms and their significance. It is difficult for the average patient to clearly describe symptomatology, and as difficult, at times, for the physician to establish the diagnosis, since the vertigo may be so mild as to be scarcely noticeable or again so severe as to incapacitate the patient. The physician might use as a standard of comparison in these varying degrees of vertigo the recollection of his own sensations when as a child he whirled around and around and said he was "dizzy." But whatever the degree of dizziness the physician should take the time, as well as have the knowledge, to clearly and carefully evaluate each case.

Various ophthalmological conditions may occasionally produce vertigo. In this category, muscle imbalance, which usually produces very mild symptoms, is the most frequent in occurrence. In neurological conditions producing vertigo the lesion is most frequently centered in the brain stem in the form of abscess, tumor, various vascular conditions associated with hypertension and arteriosclerosis, as well as post-traumatic changes. It is usual for lesions of the central nervous system to have other signs and symptoms associated with the vertigo. That of central origin is usually not severe, is often positional and generally transient.

In the majority of cases the inner ear or labyrinth is the site of origin and this labyrinthine or peripheral vertigo is usually severe with associated auditory phenomena of tinnitus and

deafness. A regular, horizontal nystagmus is present and the "whirling" sensation is accompanied by nausea or vomiting.

The peripheral origin must be investigated, but one must not assume that the ear is responsible for all the vertigo. This vertigo may be produced by:

1. labyrinthitis associated with acute or chronic disease of the ear or mastoid
2. labyrinthine irritation or toxic labyrinthitis due to drugs, infection or allergy
3. Ménière's disease
4. tumors of the 8th or acoustic nerve
5. fractures involving the temporal bone
6. concussion of the ear
7. cases of sudden vertigo and deafness of uncertain origin, including possible vascular spasm

Keeping these causes in mind, a careful detailed history and thorough physical examination are essential when proceeding with the diagnosis and treatment. In taking the history, special note should be made of the outline of the attack, its duration, the frequency and pattern of recurrence, and if any, the accompanying symptoms. Specific questions should be asked regarding postural vertigo, headaches, tinnitus, deafness, gastrointestinal disturbances and dietary and other habits. Labeling the patient with vertigo as a psychoneurotic is a common tendency, but while the functional element may be present either as a cause or as an adjunct of the vertigo, one must not assume that because of it vertigo is solely of neuropsychiatric origin.

As soon as it is decided that the patient does have a true vertigo, one must look for the cause. Physical examination must be complete. Special tests and laboratory studies must be run as indicated. It may be necessary to later have consultations with neurologist, otologist or psychiatrist.

In doing a thorough neurological examination one must include study of the function of all the cranial nerves, examination of eyegrounds for papilledema and vascular changes, and notation of eye movement. If nystagmus is present its character, duration and direction should be noted. When a lesion of the central nervous system is suspected the neurologist may determine the site of the lesion and further evaluate it.

The ear, nose and throat examination should determine the presence or absence of infection of

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the ear or mastoid, with x-rays to substantiate the findings. A hearing test, with tuning fork, is a valuable aid and should include both air and bone conduction and a comparison of the hearing in both ears. Infection of the nose and sinuses should be eliminated and the nasopharynx inspected for disease involving the eustachian tubes. A caloric test should be done. In this the patient is asked to describe his symptoms and to compare these thus produced with those of his complaint. Tests for positional vertigo should complete the examination. If it is felt the ear is the site of the vertigo an evaluation by a competent otologist is indicated to substantiate the diagnosis.

In the majority of patients the cause of the vertigo will be determined. However, there will be a percentage of cases in which it is not. Repeated examinations will be of value if the generally overlooked conditions of recent but mild upper respiratory infection, possible influenza, a mild gall bladder disease, fluctuating blood pressure or food allergy are kept in mind as a possible cause.

The treatment must first control the attack and secondly remove when possible the cause. Reassurance must be given to all patients, many of whom fear the onset of cerebral hemorrhage or that their symptoms are the initial warning of brain tumor. Symptomatic treatment must be given to all patients; in the severe cases to control the severe symptoms until a complete examination and diagnosis may be made, in the mild cases as a palliative, and in surgical cases until surgery can be undertaken.

Rest in bed with sedation such as sodium phenobarbital by hypo, gr 2 to gr 4 i.m. is indicated. Dramamine in doses of 50 to 100 mgm q.4.h. may help control the vertigo. If vomiting persists an intravenous injection of 500 to 1,000 cc. of 5 per cent glucose can be given.

When severe, prostrating vertigo is present a quick examination to elicit its cause if possible, admission to the hospital, and a slow intravenous injection of histamine is recommended. The vertigo of central origin frequently requires surgery. Central vertigo due to hypertension requires reassurance and mild sedation with control of the blood pressure, but in many cases the therapy is often unsatisfactory.

Specific therapy can be given in many cases. In otitis media, a paracentesis of the ear drum and administration of antibiotics will relieve the

vertigo. In chronic otitis media and mastoiditis vertigo is a dangerous symptom. A radical mastoid operation here is necessary. Vertigo is a late symptom of an eighth nerve tumor and treatment requires surgery. In concussion of the ear and fracture of the temporal bone expectant treatment, mild sedation and rest are indicated. Psychotherapy, of course, is indicated in all cases of functional vertigo.

Ménière's disease is due to a hydrops of the labyrinth or an increase of the fluid endolymph within the ear. True Ménière's disease must not be confused with those Ménière-like symptoms which are often as confusing. The treatment of true Ménière's disease is primarily medical, surgery being reserved for those patients who fail to respond. The low sodium salt diet of Furstenberg may be tried, but I personally prefer intravenous histamine treatment which has given relief in practically all our cases after three to six daily injections. The treatment as indicated by Horton is the slow drip method of intravenous injection of 2.75 mgm of histamine diphosphate in 250 cc. of 5 per cent glucose, commencing at the rate of about 10 drops per minute, increasing as tolerated. This may be followed by hypodermic histamine injections in small doses to maintain the desensitization. Nicotinic acid, in doses of 50 to 100 mgm t.i.d. may also produce relief.

Summary

Vertigo is a complex symptom of multiple possible origins. That of labyrinthine origin is usually severe, generally associated with deafness and with tinnitus. That of central origin is generally more mild, is positional and usually has associated signs of a central lesion. Toxic vertigo or dizziness may be due to systemic disease, metabolic disorders, drugs or be of psychogenic origin.

The primary point in the diagnosis of vertigo is the determination of the patient's definition of his symptoms of "dizziness." Complete physical examination, a thorough ear, nose and throat examination, and evaluation of the auditory and labyrinthine functions are necessary before the final diagnosis may be made.

The few cases in which the cause cannot be determined may be relieved by symptomatic treatment. Certain specific treatment is helpful in the majority of cases, and the therapy may be medical or surgical.

Headaches

Etiology and Treatment

By Russell N. DeJong, M.D.

Ann Arbor, Michigan

A HEADACHE, like any other pain, is a symptom and not a disease. Consequently, the diagnosis and attempts at treatment of a headache, as such, are not sufficient. The physician, if possible, must diagnose the type and etiology before attempting to institute therapy. The presence of a headache, especially if severe or frequent, should always warrant a complete investigation of the patient, by both history and examination, in order to recognize or exclude one or another of the possible serious causes.

A headache is said to be one of the most common ills to which the human race is heir. It is one of the most frequent presenting complaints of patients who seek medical help, not only from the neurologist, but also from the ophthalmologist, otolaryngologist, gynecologist and other specialists, and especially from the general practitioner of medicine. The symptom may be of minor significance in many instances, but it also may be the first symptom of a grave organic disease; it may be of either organic or psychogenic origin.

Anatomy and Physiology

In order to understand why and how headaches occur, it is of value to review briefly the anatomic and physiologic backgrounds of head pain, including the mode of production and the structures involved.^{8,19,21} The scalp, galea aponeurotica, fasciae and muscles of the head are all sensitive to painful stimulation such as cutting, crushing and tension. The periosteum of the skull is sensitive only low in the temporal, frontal and occipital regions. The cranial bones, including the diploe, are insensitive. The extracranial arteries are very sensitive, especially to distention and especially in their larger divisions, and the pain is referred to the region of distribution of the artery. The extracranial veins are only slightly sensitive. Of the meninges, the dura over the cortex is insensitive except along the sinuses and arteries. The basal

dura, however, is extremely sensitive; if that of the anterior fossa is involved, the pain is referred to the homolateral eye, and affection of that in the posterior fossa causes pain to be referred to the homolateral ear. The falx is sensitive only along the margin of the superior longitudinal sinus. Traction on or distention of the dural sinuses causes severe pain; this is referred to the vertex if the superior longitudinal sinus is involved and to the eye or ear if the transverse sinus is affected.

The pia and arachnoid are insensitive, as are the cortex and parenchyma of the brain. Of the intracranial vessels, the cerebral veins are sensitive only to traction. The vessels of the pia and arachnoid are insensitive. The intracranial arteries, however, are extremely sensitive to pressure and trauma. The choroid plexus and walls of the ventricles do not react to stimulation, but distention of the ventricles, if followed by severe pain. Distention of the lateral ventricles causes pain which is referred to the frontal area, and distention of the third ventricle causes generalized pain. In summary then, the skull, dura and brain are insensitive except for the dura along the base and the dural sinuses. The vessels are sensitive to pain, especially the extracranial and intracranial arteries. The scalp and its muscles are pain-sensitive.

Dr. Harold Wolff and his co-workers, through detailed experimental studies, have summarized six basic mechanisms for headaches. These are as follows: (1) traction on or displacement of the venous sinuses or their contributing veins; (2) traction on the middle meningeal artery; (3) traction on the large arteries at the base of the brain and their main branches; (4) distention or dilatation of the intracranial arteries (both extracerebral and intracerebral); (5) inflammation in or about any of the pain-sensitive structures of the head: the muscles, tendons, fasciae and basal dura; (6) direct pressure, as by tumors, on the cranial or cervical nerves carrying pain afferent fibers from the head. Traction, distention, displacement or inflammation of the cranial vascular structures is chiefly responsible for intracranial pain, and involvement of the muscles, tendons and fasciae, or direct affection of the sensory nerves, for extracranial pain. Almost all, if not all, causes of headache can be explained by one of the above mechanisms.

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This article is being translated in Portuguese and published in the *Resenha Clinico-Cientifica*, Brazil.

History and Description

An adequate history and description of the headache is essential to diagnosis. Patients often think that they have given sufficient information if they merely mention the symptom, but an accurate characterization of the headache is necessary. It is important to recall that a headache is a pain and therefore it is entirely subjective, and one must rely upon the patient's description of the pain in order to arrive at a diagnosis. The following features of the pain should be considered.^{3,22}

1. *Localization and Paths of Radiation.*—The pain may be frontal, vertical, occipital or temporal; it may be unilateral or bilateral, or localized or diffuse. In *migraine* the pain is most frequently of the hemicranial type, starting in the supraorbital area and radiating back to the occiput on the same side. It may vary from side to side in attacks, and occasionally is bilateral. The headache in *sinus disease* is frequently in the frontal area or behind the eyes. The headache of *ocular disease* is either frontal or occipital. In *brain tumors*, *brain abscesses* and *ear disease* the pain is often unilateral. In *uremia*, it may be frontal or occipital. The pain associated with *myalgia of the muscles of the neck and cervical arthritis and fibrositis* is in the occipital region, radiating to the temporal areas bilaterally. *Psychogenic headaches* may be in this same location, or they may vary in site or type. Frequently, they are band-like in distribution, or may be characterized by a pressure sensation at the vertex.

2. *Character of the Pain.*—It may be steady, paroxysmal, or intermittent; dull, throbbing or boring; or sharp or lacerating.

3. *Intensity of the Pain.*—This is often difficult to evaluate. The physician must depend largely upon his interpretation of the patient's reaction to pain. Some individuals may complain bitterly of a pain that to others may be minor in significance. One can often get some clue regarding the intensity by inquiring whether the pain interferes with work or sleep, and whether it incapacitates the patient for his routine duties. It is often of value to determine whether it interferes with pleasurable activities as well as with work.

3. *Incidence, Mode of Onset, Duration and Frequency.*—Here one inquires about the perio-

dicity of occurrence, time interval during the day or month, seasonal factors, and the relationship to food, movement, exercise, position, coughing, mental effort, use of the eyes, temporal or jugular compression, rest and sleep, emotional stress and strain, or changes in mood. Migrainous headaches are often noted on arising in the morning, or may come on at periods of stress or strain. Other causes of morning headaches may be poor ventilation, the presence of fumes in the room, sensitivity to feathers, and slight degrees of astigmatism or hypermetropia. Headaches that occur early in the morning and awaken the patient are often due to organic disease of the brain or meninges. This is especially true of so-called hypertensive headaches which frequently awaken the patient early in the morning and leave shortly after he arises. Persistent morning headaches may be due to nephritis. Headaches that come on in the evening are often due to mental overwork, fatigue and eyestrain. The *mode of cessation* is also important. The headache may cease gradually or abruptly; it may be relieved by rest in a dark room, a frequent manifestation of migraine. Hypertensive headaches are relieved with activity. Headaches on toxic and febrile bases are often relieved by rest. Response to therapeutic measures may be a valuable diagnostic aid.

4. *Localized Tenderness.*—In sinus disease, there is often tenderness to pressure over the paranasal sinuses; in brain tumors and subdural hematomas there may be localized tenderness on the side of the lesion. In the so-called *clavus hystericus*, there are localized areas of tenderness within the scalp. These may be so acute that even movements of the hair may cause the pain.

5. *Associated Phenomena.*—Nausea, vomiting, and other gastrointestinal symptoms are often found in migraine. On the other hand, vomiting also occurs in headaches due to increased intracranial pressure, but here the vomiting is often precipitate or projectile and not associated with nausea. Ocular manifestations such as burning of the eyes, smarting of the eyes, photophobia, diplopia, hemianopia, blurred vision, or sleepiness or fatigue with the use of the eyes may be of significance. The burning and fatigue on use of the eyes might indicate ocular origin of headaches. Diplopia, photophobia, hemianopia, hyperacusis and hyperosmia may be present during migrainous attacks. Photophobia is also an early symptom

in meningitis. In vascular disease and organic brain disease there may be vertigo, syncope, lowering of consciousness, confusion, aphasia, paralyses and paraesthesias. With headaches due to increased intracranial pressure, or due to toxic or febrile causes, there may be drowsiness and confusion which may terminate in convulsions and coma. In infectious processes, there is fever with elevation of the pulse and respiratory rates, while in headaches due to increased intracranial pressure there may be a bradycardia and decreased respiratory rate. In meningeal irritation and subarachnoid bleeding, there is marked stiffness of the neck. In arteriosclerosis and hypertension, there may be vertigo and tinnitus. In allergic headaches there may be vasomotor changes with lacrimation and flushing.

The history should always be followed by a thorough examination of the patient. A complete physical evaluation, of course, should be carried out to eliminate any systemic cause for the symptoms. A neurologic examination is necessary. In many instances, examination of the eyes, paranasal sinuses and ears is essential. Allergy studies may be of value. Auxiliary examinations, such as biochemical tests, skull roentgenograms, basal metabolic rate determination, blood and urine studies, or spinal puncture, may be necessary. On occasions, special diagnostic procedures, such as electroencephalography and pneumoencephalography, may be indicated. Sometimes the diagnosis can be made by provocation of the headache by means of histamine or other vasodilators, or therapeutic tests with ergotamine tartrate or epinephrine.

Differential Diagnosis

In discussing the differential diagnosis of headaches, one may classify them into three groups: the acute, the occasional, and the chronic, periodic or recurrent headaches. In the first group, the diagnosis is usually not too difficult, and, of course, treatment follows determination of cause. *Acute headaches* are frequently associated with febrile diseases such as typhoid, pneumonia or malaria. They may occur with exposure to toxins, or with acute ear or sinus disease. They may be present in uremia, in grave illnesses such as meningitis, and with cerebral or subarachnoid hemorrhage. *Occasional headaches* may be associated with excessive fatigue, unusual eye strain, or may be emotionally precipitated by tension, mental overactivity, emotional strain, worry, anger, excitement, frustration,

or resentment. They are sometimes brought on by excessive eating, excessive drinking, omission of meals, or lack of sleep; in fact, they may be precipitated by either organic or psychologic variations from the normal life routine. Also in this group we should probably include the not unusual hangover headaches and spinal puncture, post-convulsion, and acute post-traumatic headaches. These are all relatively simple, as far as diagnosis is concerned. Some respond to the usual analgesics, but for others more prolonged therapy is necessary.

The headaches that present the major problem in regard to both diagnosis and treatment are the *recurrent, periodic and chronic headaches*. It is in these that we are obliged to carry out complete diagnostic studies. One must always bear in mind that even though brain tumor is not one of the common causes of headaches, many patients with chronic, undiagnosed headache seek help because they have either a conscious or unconscious fear that they may have such a lesion, and it may be of value to carry out certain additional diagnostic studies which the physician, himself, may not think entirely necessary, just to help to reassure the patient that such a lesion is not present.

In a complete discussion of the etiology and treatment of headaches, one should include those of ocular origin; those associated with diseases of the ears, nose, throat and paranasal sinuses; those of allergic origin; and those associated with toxins, infections, systemic disease, hypoglycemia, temporal arteritis, diseases of the cervical spine and muscles, intracranial lesions, and endocrine or metabolic disturbances, among others. In this large group, however, specific treatment must be directed toward the primary etiologic factor, and the headaches, themselves, are treated symptomatically with analgesics. In the present discussion, however, I would like to concentrate on a few of the most common causes of chronic and recurrent headaches. It has been found from a review of large groups of patients that the most frequent causes for chronic and recurring headaches are migraine and atypical migrainous syndromes, hypertension and other vascular diseases, trauma and the posttraumatic state, and psychogenic disorders. These will be discussed individually.

Migraine

A migraine headache is a specific type of recurrent headache which occurs in individuals who are otherwise well. It is oftentimes severe and

incapacitating, and may last from half an hour to three or four days. It has been estimated that 5 per cent of the population are subject to this type of cephalalgia. It occurs in both sexes, although two to three times as frequently in women as in men, and in women the attacks frequently occur at the time of the menstrual periods, and may be absent during pregnancy and after the menopause.

The headache is dull, throbbing or piercing in type, and is frequently restricted to one half of the head. It often starts over one eye and radiates backward, although it may start at the back of the head and proceed forward. It may alternate from side to side in attacks. There is frequently a family history of migraine. The attacks are often accompanied by visual symptoms such as scotomas, blurred vision, or even hemianopia, and by gastrointestinal manifestations such as nausea, vomiting or anorexia. The individual attack may be preceded by an aura characterized by drowsiness, depression, a feeling of exhaustion, nervousness or irritability. Other accompaniments such as vasomotor changes, paresthesias, or even pareses have been described. It is known at the present time that a migraine headache is a vascular phenomenon, and the pain itself is caused by dilatation of certain extracranial arteries, especially the branches of the external carotid. The dilatation may be preceded by spasm, which accounts for the preceding visual phenomena.

Various etiologic factors have been hypothesized, and it is known the allergic, endocrine and metabolic changes may be at the basis of a certain percentage of migraine, but the individual attacks are in most instances precipitated by psychologic factors. It has been found that the patient who is subject to migraine has certain personality characteristics. The attacks, while they may occur in individuals of all walks of life, are more frequent in the "thinkers" than in the "doers"; that is in the professional and semiprofessional groups. Patients subject to migraine are likely to be tense, nervous, worrisome, overly conscientious individuals who work hard but fatigue easily. They are sensitive to criticism and are subject to doubts and fears. They react strongly to all stimuli. The woman who is subject to migraine is likely to be a meticulous, fastidious housewife, and the man is often overambitious and exacting, with an exaggerated sense of responsibility and a perfectionistic attitude toward himself and everyone else. In people of

this type, any change from the normal may bring on an attack; fatigue, overwork, loss of sleep, worry, hunger, anger, frustration, or excitement may be the precipitating or contributing factors.

In treating migraine, two objectives are to be borne in mind. First, treating or shortening the individual attack, and, second, the prevention of recurrence or lengthening of the intervals between the headaches. The first principle in treating the attack is to start the moment the first sign of trouble appears. The earlier the treatment is started, the more successful it will be. If the attack is mild, aspirin or some allied analgesic often accompanied by a mild sedative or by caffeine may bring about adequate relief, and the patient may be able to continue with his normal activity. If the attack is more severe, he may have to rest in a darkened room for a period of time. Sometimes, the application of cold packs to the head may give relief. Occasionally, the patient notices relief from the pain following vomiting, and some individuals even induce vomiting.

It has been found in recent years that ergotamine tartrate or gynergen is specific in some seventy to ninety per cent of patients with migraine.^{5,6,15,18} It is so successful that it may be used as a therapeutic test. Standard ergotamine tartrate is given either by mouth or parenterally. Tablets of 1 milligram are available for oral or sublingual use; one or two to four or five tablets may be taken at the onset of a headache and additional tablets may be taken at half hourly intervals. Ampules of one half milligram given subcutaneously or intravenously will bring about more dramatic relief. Ergotamine sometimes causes gastrointestinal disturbances, especially if it is taken after the headache is at its peak. These, on occasion, may be relieved by the use of atropine. Dihydroergotamine has been found to be somewhat safer and less likely to produce gastrointestinal upsets.^{2,13} This is administered parenterally in doses of one to two milligrams. Recently, a new compound, cafergot, which is a combination of one milligram of ergotamine together with 100 milligrams of caffeine, has been found to be more effective than ergotamine alone; possibly the added caffeine works synergistically with the ergotamine.^{10,14} Suppositories of cafergot are now available experimentally and these have been found to be even more effective in some cases than the oral cafergot. The suppository works more quickly than the oral preparation,

and it may be given to individuals who cannot take oral medicine because of nausea. Many other drugs, including nicotinic acid, thiamin, histamine (see below), octin,¹⁶ endocrine products and calcium, have been reported to be of value in individual cases of migraine, but the above preparations are the most important and the most specific. They are safe when used in therapeutic doses, but must be avoided in hypertension and coronary and peripheral vascular disease. Dihydroergotamine can be used during pregnancy. Narcotics should be strictly avoided in migraine.

The second objective in the treatment of migraine is the prevention of the attacks or the lengthening of the intervals between them. It is important to review the patient's case thoroughly, and to remove all possible precipitating causes or underlying mechanisms, including allergic factors, toxins, infections, endocrine changes, et cetera. The most important measure, however, in relieving the disorder, is to treat the total personality, to help the patient to understand why he is having the attacks and to avoid the precipitating causes. Personality readjustment, correction of erroneous ideas of living, and elimination of undesirable environmental factors are the most important parts of the therapy.

Atypical Migrainous Syndromes

Atypical migrainous headaches and migraine equivalents and variants may include many variations and *formes frustes*. Many of these are difficult to differentiate from the psychogenic headache to be discussed later. In some instances they respond to therapy with drugs of the ergotamine group, although often they require more individual therapy.

One specific type of the atypical migraine is the so-called *histamine cephalalgia* of Horton, also known as erythromelalgia of the scalp.^{11,12} The pain here is also unilateral, but it is restricted to the eye or supraorbital area. It is briefer in duration than migraine, and the individual attacks often last from only twenty minutes to an hour. The pain frequently comes on at night and awakens the patient. He gets out of bed and sits in a chair, and in a short period of time the pain leaves and he can return to sleep; he may, however, have two or three such recurrences during the night. This type of headache is very rarely accompanied by vomiting, but there is usually congestion of the conjunctive on the affected side,

with lacrimation and unilateral rhinorrhea. The manifestations are frequently periodic, and the patient may have daily (or nightly) attacks of pain for a period of six weeks to two months and then be free from symptoms for six months or so, followed by a recurrence lasting for six weeks to two months. While the attacks occur most frequently in the spring and fall, no seasonal relationship is definitely observed.

These headaches may be precipitated by the subcutaneous injection of 0.3 to 0.5 milligrams of histamine phosphate (0.3 to 0.5 cc. of a 1:1000 solution) and relieved by the subcutaneous injection of 0.2 to 0.3 milligrams of epinephrine (0.2 to 0.3 cc. of a 1:1000 solution of epinephrine hydrochloride). This headache is probably also of vascular origin, and the pain probably results from dilatation of branches of the internal carotid artery. Histamine desensitization has been recommended for relief of the syndrome. This is carried out by the subcutaneous injection of increasing doses of histamine, starting with 0.025 milligram of histamine base and working up to 0.1 milligram, giving this amount twice daily for eight days, then every other day, and finally once a week as a maintenance dose. It has also been treated by the intravenous administration of 2.75 milligrams histamine acid phosphate in 250 to 500 cubic centimeters of saline solution given daily for three or four injections. This latter mode of histamine injection has also been recommended in the treatment of migraine.^{1,17} While the histamine cephalalgia is very probably a result of sensitivity to histamine, the above procedures are not uniformly successful in relieving the headache. The attacks themselves are often helped by the use of ergotamine tartrate or related drugs, and recently very good results have been obtained in some cases by the use of the cafergot suppositories.

Hypertension and Other Vascular Diseases

Chronic vascular disease, either arteriosclerosis or hypertension but usually the latter, is a common cause of headaches, especially in elderly individuals. It is stated that 45 per cent of the patients with hypertension have headaches. There is often associated tinnitus and vertigo and there may be vomiting, transient paralyses or paresthesias, periods of aphasia, confusion, memory loss, emotional lability, and general evidence of loss of cerebral function. The typical hypertensive

headache comes on about four or five o'clock in the morning. It awakens the patient and may go away when he gets up. It is associated with increased intracranial pressure, but not relieved by decrease of such pressure. It is interesting that the hypertensive headache is sometimes relieved by splanchnicectomy even though the blood pressure does not remain low after such an operation. Severe headaches may occur with either cerebral hemorrhage or subarachnoid bleeding. Increasing severity of headache may precede an intracerebral ictus, but in subarachnoid hemorrhage the pain may come on precipitously. The latter diagnosis should be borne in mind if there is a sudden onset of severe nuchal or occipital pain with resulting meningeal signs, retraction of the neck, photophobia and confusion. The diagnosis can be confirmed by spinal puncture.

Posttraumatic Headaches

Posttraumatic headaches often constitute a difficult problem in both diagnosis and treatment. The pain which follows immediately after a head injury is not difficult to treat and usually responds to analgesics and sedatives; sometimes the intravenous injection of hypertonic sucrose or the removal of cerebrospinal fluid by the lumbar route is of value. It is important in the immediate posttraumatic headache to reassure the patient and minimize his symptoms, and to encourage early ambulation. The headaches that persist long after injury or gradually become worse constitute a more challenging problem.²⁰ They may appear singly or in association with such symptoms as dizziness, difficulty in concentration, nervousness, and insomnia. The headaches are often localized or bursting in type; they are sometimes increased by increasing the intracranial pressure as in coughing, sneezing and stooping. They are aggravated by mental or physical exertion. They may be absent in the morning or on lying down, and come on when the patient is up and about. They are relieved by rest. They may be associated with irritability, emotional outbursts, mental or personality change, and decreased tolerance to alcohol.

There are many theories regarding the pathophysiology of posttraumatic headaches. Some authors consider them to be entirely physiologic, some entirely psychologic, and others feel that both factors are important. The physiologic mechanisms involved include distention of cranial

blood vessels, sustained contractions of the muscles of the scalp and neck, and scarring of the extra- and intracranial soft tissues. Psychogenic factors include the immediate emotional effect of the injury, that is, anxiety, depression, resentment or frustration; pretraumatic neurotic ideas or tendencies; and psychic conflicts due to environmental stresses incident to the injury. If no organic changes are found in the neurologic examination, electroencephalogram, pneumoencephalogram, or spinal fluid examination, one must feel that organic factors are absent or minimal, and may, in most instances, assume that psychogenic factors are the more important ones. The treatment, of course, is the treatment of the whole person, and is mainly a psychotherapeutic problem.^{4,7,9} Reassurance is important. Habit-forming drugs should be avoided, and every attempt should be made to explain the situation fully and truthfully to the patient. In general, the treatment must be similar to that in the next group, the psychogenic headaches. In a few isolated instances procedures such as pneumoencephalography, probably to free meningeal adhesions, or even neurosurgical intervention, is indicated. One must always be sure, however, in the treatment of the posttraumatic headache, that he is not dealing with a subdural hematoma or some other grave intracranial condition.

Psychogenic Headaches

By far the largest group of headaches are the so-called psychogenic ones.^{4,7,9} The pathophysiology of some of these is understood. Some are on a vascular basis associated with relaxation or dilatation of arterial walls; some are associated with tension and spasm of the extracranial muscles and related structures. Psychogenic headaches may be of various types. Sometimes the pain is an occipital or low cervical one with radiation of the temples, sometimes it is at the vertex, sometimes it is band-like in distribution. In many patients the headache varies from time to time as to location, type and severity. Fatigue, mental strain, emotional conflict, frustration, and resentment are often precipitating or underlying factors, and the headaches may be made worse by emotional stress and inner conflicts. Patients with headaches of this type represent a challenging therapeutic problem to the practitioner. Many patients have already consulted many different physicians and have had various treatment regimes

advised, including analgesics, sedatives, vitamin preparation, hormones, et cetera. Often we get the history that there is temporary relief with every new physician and with every new therapy, but still the headaches persist and interfere with the patient's work, his home life, or his domestic or marital duties. In these patients symptomatic treatment should be limited as much as possible, because they soon become dependent upon analgesics and sedatives, and require increasing doses of them. On the other hand, there are some patients with psychogenic headaches who get no benefit from analgesics and even narcotics, and occasionally a diagnostic criterion for psychogenic headaches is that the pain is not relieved even by large doses of narcotics.

It is important that the physician gain the patient's confidence; that he understand his background, his early development, and his home and work situations, so that he may comprehend the factors which bring on the pain. It is essential to help the patient to understand that anxiety, fear, depression and frustration may cause physiologic changes that may bring on the headache. One may explain, for instance, that tension of the posterior cervical muscles may irritate the afferent cervical nerves and cause pain in the temporal and occipital distribution; that anger and resentment may cause vascular changes within and without the skull, similar to the vasodilatation which occurs with blushing and the vasoconstriction which occurs with fright, and that these vascular changes within the skull can bring on the pain. The important part of the treatment, however, is the treatment of the total personality, helping the patient to understand his conflicts and to overcome his anxieties and tensions.

Conclusion

Headaches may be caused by many different factors and processes. They may be a result of localized intracranial disease, they may be a symptom of systemic illness, or they may be a result of trauma or of emotional conflict and psychogenic disturbances. The etiology must always be determined before treatment is undertaken. It is important to bear in mind, however, in the therapy of all types of headaches, that a two-fold approach may be necessary. Analgesic drugs may be used for the symptomatic treatment of headaches due to systemic disease and for transient

relief in those of psychologic origin or posttraumatic in onset, and drugs of the ergotamine group for migrainous headache and atypical migraine. Secondly, psychotherapy should be instituted in order to relieve emotional tensions and help the patient to cope with difficult life situations. The results of the latter are often quite gratifying, even when only simple supportive psychotherapy is given.

References

1. Butler, S., and Thomas, W. A.: Intravenous histamine in the treatment of migraine: Preliminary observations. *J.A.M.A.*, 128:173 (May 19) 1945.
2. Clien, N. W.: D.H.E. 45 (Dihydroergotamine) in the treatment of allergic migraine. *Ann. Allergy*, 4:128 (March-April) 1946.
3. DeJong, R. N.: *The Neurologic Examination, Incorporating the Fundamentals of Neuroanatomy and Neurophysiology*. pp. 14-15. New York: Paul B. Hoeber, Inc., 1950.
4. Friedman, A. P., and Brenner, Charles: Principles in the treatment of chronic headache. *New York J. Med.*, 45:1969 (Sept. 15) 1945.
5. Friedman, A. P., and Brenner, Charles: Treatment of the migraine attack. *Am. Pract.*, 2:467 (March) 1948.
6. Friedman, A. P., and von Storch, T. J. C.: Recent advances in the treatment of migraine. *J.A.M.A.*, 145:1325 (April 28) 1951.
7. Friedman, A. P.; Brenner, Charles, and Carter, Sydney: Symptomatic treatment of certain types of chronic headache. *J.A.M.A.*, 139:195 (Jan. 22) 1949.
8. Friedman, A. P.; Brenner, Charles, and Merritt, H. H.: Experimental evidence of the physiologic mechanism of certain types of headache. *Arch. Neurol. & Psychiat.*, 54:385 (Nov.-Dec.) 1945.
9. Friedman, A. P.; Brenner, Charles, and Merritt, H. H.: Management of patients with chronic headache. *J.A.M.A.*, 132:498 (Nov. 2) 1946.
10. Hansel, F. K.: The treatment of headache with particular reference to the use of cafergone (ergotamine tartrate and caffeine) for the relief of attacks. *Ann. Allergy*, 6:155 (March-April) 1949.
11. Horton, B. T.: The use of histamine in the treatment of specific types of headache. *J.A.M.A.*, 116:377 (Feb. 1) 1941.
12. Horton, B. T.; MacLean, A. R., and Craig, W. McK.: A new syndrome of vascular headache: Results of treatment with histamine; Preliminary report. *Proc. Staff Meet. Mayo Clin.*, 14:257 (April 26) 1939.
13. Horton, B. T.; Peters, G. A., and Blumenthal, L. S.: A new product in the treatment of migraine: A preliminary report. *Proc. Staff. Meet. Mayo Clin.*, 20:241 (July 11) 1945.
14. Horton, B. T.; Ryan, R., and Reynolds, J. L.: Clinical observations on the use of E. C. 110, a new agent in the treatment of headache. *Proc. Staff Meet. Mayo Clin.*, 23:105 (March 3) 1948.
15. Lennox, W. G., and von Storch, T. J. C.: Experience with ergotamine tartrate in 120 patients with migraine. *J.A.M.A.*, 105:169 (July 20) 1935.
16. MacNeal, P. S., and Davis, David: The use of methyl-iso-octenylamine in migraine. *Ann. Int. Med.*, 26:526 (April) 1947.
17. Macy, Dorothy, and Horton, B. T.: Treatment of migraine with histamine. *J.A.M.A.*, 137:1110 (July 24) 1948.

(Continued on Page 714)

Chronic Intestinal Disease

Diagnosis and Treatment

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CHRONIC DISEASE of the gastrointestinal tract constitutes a large segment of the general practice of internal medicine. Furthermore, chronic symptoms referable to disturbance of function of this physiologic system are frequently encountered in pathologic conditions of other organs and systems. Consequently, diseases of the digestive tract frequently enter prominently into many problems of differential diagnosis. It follows that reasonable familiarity with the more common diseases of the intestinal tract is as important to the practitioner of internal medicine as to the specialist.

The fact that symptoms may be primary, or secondary to pathologic conditions in other regions of the body which cause remote functional disturbances, emphasizes the need for a detailed and complete history before attempting to evaluate physical findings or the planning of laboratory and x-ray examinations. The history when taken with careful attention to complete description of the individual symptoms will frequently provide strong presumptive evidence that the condition under consideration is or is not primary in the gastrointestinal tract.

The clinical phenomena which the patient may note may be classed in three general categories: cardinal symptoms, associated symptoms and cardinal signs. The cardinal symptoms of gastrointestinal disease are: abdominal pain, nausea, vomiting, diarrhoea, constipation, cramps and tenesmus. All of these, however, may be the expression of pathologic conditions in other parts of the body.

Pain may be highly significant and its description and localization of the utmost importance. Thus pain in the epigastrium is usually due to lesions in the stomach, duodenum, gallbladder, or pancreas. When it is due to peptic ulcer, the patient may be able to localize it sharply at a

point between the xiphoid and the umbilicus. Gallbladder pain is usually more diffuse in its localization and is generally referred to the right upper quadrant. In duodenal ulcer, in addition to the anterior abdominal pain, there may be pain in the back at the level of the eighth to the tenth thoracic vertebrae, and more rarely back pain may occur alone. In esophageal lesions pain is generally substernal corresponding to the level of the lesion. However, it may be accompanied by substernal pressure and may radiate to the left shoulder and arm strongly suggesting angina pectoris. Pain originating from disease of the small intestine generally is localized in an area just above and just below the umbilicus. When produced by lesions in the colon, except in the region of the points of fixation, pain is usually referred to the midline at or below the level of the iliac crests. When it originates from the areas of the fixed points of the colon as the hepatic and splenic flexures and the sigmoid, pain is usually localized in the area of involvement. Pain resulting from lesions of the rectosigmoid is also referred to the midline in the suprapubic area or to the midline of the sacrum. Similarly, pain originating in the rectum is commonly suprapubic or sacral and only rarely when the disease process is in the ampulla is it perineal in its localization.

Nausea is far less useful as a sign of intrinsic gastrointestinal disease since it is a frequently encountered symptom in a variety of conditions in which the primary process lies outside the gastrointestinal tract. Vomiting, likewise, is seldom helpful in localization since it is a frequent symptom in a wide variety of disease conditions.

Diarrhoea, also, occurs in many conditions both systemic and gastrointestinal. Constipation, on the other hand, may have definite significance especially if it occurs in an individual who previously has had normal intestinal function.

Low abdominal cramps are strongly suggestive of a pathologic process in the colon especially the proximal portion. Tenesmus, on the other hand, is indicative of irritation of the descending and pelvic rather than the proximal colon.

Associated symptoms such as belching, flatulence and meteorism may or may not have considerable weight in the primary diagnosis. Belching is a frequent complaint but it seldom has diagnostic significance. However, chronic flatulence and especially meteorism in the presence of certain of the cardinal symptoms may strongly suggest

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Presented before the Michigan State Medical Society, Grand Rapids, Michigan, September 27, 1951.

the possibility of an obstructive lesion of the intestinal tract involving the lower small intestine or the colon.

Certain objective phenomena which the patient may have noted may have considerable importance in arriving at a primary diagnosis and determining the lines of further investigation. These cardinal signs include the type of stools, the frequency of evacuation, the color of the dejecta, and the presence of gross blood, pus or mucus.

The type and frequency of evacuation may give an indication of the nature of the pathologic process and of its severity. Clay colored stools suggest obstructive jaundice or steatorrhoea. Stools which are abnormally dark in color point to bleeding in the upper portion of the intestinal tract, while red blood, mucus and pus are commonly indicative of a lesion of the colon. While none of these symptoms or cardinal signs is pathognomonic, when taken together, the history frequently permits accurate interpretation and immediate choice of the additional diagnostic methods necessary to reach definitive diagnosis.

The following discussion of clinical conditions is restricted to certain of the more important chronic diseases of the small intestine and the colon. Peptic ulcer is excluded because of its frequent occurrence and familiarity. The conditions under consideration may be classified in four general categories: congenital malformations, the results of infection and inflammation, benign and malignant tumors, and primary and secondary nutritional defects. While it is obviously impossible to discuss all of these conditions in detail, the attempt will be made to emphasize the salient features which are of assistance in definitive diagnosis, and to indicate the general lines of therapy.

Congenital anomalies of the small intestine are not particularly uncommon. Bands producing varying degrees of obstruction of the duodenum occur in about five per cent of patients. The most common variety probably represents persisting foetal structures binding the duodenum to the liver, gallbladder or hepatic flexure of the colon. A second type which is responsible for partial obstruction of the second and third portions of the duodenum is produced by the structures normally crossing this portion of the tract and the obstructive phenomena result, apparently, from abnormal mobility of the proximal colon. The third and least common anomaly is non-rotation of the

duodenum which may or may not be associated with non-rotation of the colon.

These congenital defects may not be accompanied by symptoms. When clinical phenomena are present, they are the expression of irritation or obstruction, or both. The characteristic symptom of duodenal irritation is hunger pain; those of obstruction are pain shortly after eating, nausea and vomiting. Considerable if not complete relief of symptoms may be obtained in some cases by assuming the knee-chest position or the right lateral position. While the symptomatology may be highly suggestive, definite diagnosis depends upon the findings at x-ray. Treatment whenever possible should be by conservative medical measures.

Diverticula of the duodenum occur in 1 to 2.3 per cent of individuals.⁹ They are located most frequently in the second portion, in the vicinity of the papilla of Vater and may be single or multiple. They are usually asymptomatic but may be accompanied by pain. Treatment when required is purely symptomatic.

Duodenitis, as the name implies, is a localized inflammatory process which is accompanied by symptoms closely resembling those of ulcer. However, the pain is apt to be more diffuse and relief from food or alkali is less complete. Hemorrhage occurs not infrequently, but uncomplicated duodenitis is not associated with gastric retention or other evidence of obstruction. The treatment is that of ulcer.

Primary tumors of the duodenum, benign or malignant, are extremely rare.

The jejunum and the ileum are subject to a much greater variety of pathologic conditions. Diverticula are rare and generally asymptomatic. Meckel's diverticulum, however, the persisting remnant of the normally obliterated omphalo-mesenteric duct, occurs in about 2 per cent of adults. It is located on the antimesenteric border of the intestine within a meter of the ileocecal valve. Hemorrhage beginning in childhood and recurring intermittently, obstruction and perforation are the more common expressions of this anomaly. Five clinical syndromes are ascribed to it.⁶ In the first, peptic ulcer of the ileum occurs. This may cause severe hemorrhage, perforation and peritonitis. The second group is characterized by obstruction resulting from intussusception, volvulus, hernia or adhesions. The third, which clinically may resemble acute

appendicitis, is the result of inflammation of the sac. In the fourth group fecal fistula or prolapse of the small intestine into an umbilical hernia may occur. And finally, the diverticulum may be the site of benign or malignant tumor formation of various types. In almost all instances diagnosis must be made on clinical grounds. In all cases of obscure bleeding this condition must be kept in mind. Treatment is surgical excision.

The most important chronic inflammatory diseases of the small intestine are tuberculosis and regional ileitis. Primary tuberculosis of the intestine is rare and has decreased in prevalence with the widespread adoption of pasteurization of milk and the control of tuberculosis in dairy cattle. Diagnosis of this condition is very difficult. Secondary tuberculosis is not uncommon. It is the most frequent complication of advanced pulmonary tuberculosis and lesions can be demonstrated in over half of the fatal cases coming to autopsy. Diagnosis is not difficult when chronic intestinal symptoms develop in a patient with advanced pulmonary disease, especially if a tumor mass is present in the right lower quadrant. X-ray examination will usually demonstrate one or more of the significant signs: abnormal filling and emptying of the terminal ileum and a filling defect of the cecum.

Until comparatively recently there has been no specific or effective therapy. With the advent of streptomycin and the less toxic dihydrostreptomycin the prognosis has been greatly changed. It has proved to be most effective in relieving symptoms and producing corresponding regression of the radiographic evidence of pathology.¹⁵

Regional ileitis was first described by Crohn and his associates in 1932.⁴ It is a non-specific inflammatory process usually involving the terminal ileum but often affecting other areas of the ileum or jejunum, the so-called "skip areas." It is characterized by mucosal ulceration, fibroblastic proliferation and thickening of the intestinal wall and of the mesentery with secondary lymphatic obstruction. Adhesion occurs to adjacent loops with the formation of a mass and internal and external fistulae are frequent complications. The disease commonly affects males more often than females. It is usually observed in individuals between the ages of twenty and forty.

It runs a chronic course with exacerbations and remissions with progressive risk of obstruction, perforation and peritonitis. During the periods of

activity there is low-grade fever, abdominal pain, distention varying with the degree of obstruction, diarrhoea, weight-loss, anemia and progressive malnutrition. Diagnosis in the well-marked case is not difficult since a mass in the right lower quadrant is usually palpable, and x-ray examination will reveal the characteristic deformities of the affected portion of the intestine together with disturbance of motor function.

Treatment is not entirely satisfactory. In the presence of definite obstruction surgery is, of course, required. Extensive resection, formerly recommended, has been largely replaced by short-circuiting procedures. Medical treatment at times is relatively effective in the milder cases. Although certain of the sulfonamides and certain of the antibiotics appear to induce a remission in individual cases, there is no uniformity of response. In all instances the individual must be kept under long observation with recognition of the probable ultimate necessity for surgical intervention.

Tumors of the small intestine are as rare as those of the colon are common. They are frequently the cause of intussusception, obstruction or hemorrhage. There is no characteristic clinical picture on which diagnosis may be based.

Idiopathic steatorrhoea is a clinical syndrome characterized by abnormal amounts of fatty acids and soaps in the stools, progressive malnutrition and anemia. Clinically, it closely resembles and may, in fact, be identical with the three conditions: tropical sprue, non-tropical sprue and celiac disease. In the typical case the patient gradually develops morning diarrhoea, the stools becoming more bulky, light in color and acid in reaction. Usually abdominal distention is prominent. More or less coincidentally, the tongue becomes red, inflamed and sore, with inflammation of the papillae followed by atrophy ultimately producing the characteristic smooth tongue. Aphthous ulcers of the tongue and buccal mucosa are usual, and dysphagia may be a troublesome symptom in acute cases. There is progressive loss of weight, development of hypochromic anemia and other indications of progressive malnutrition. The disease is characterized by remissions, but with each exacerbation it tends to become more severe and ultimately macrocytic anemia appears.

The etiology is unknown. There is no specific pathology and the lesions are merely those of atrophy, probably an expression of the malnutrition. The gastric acidity may be normal or

anacidity may be present. Pancreatic function is normal on secretin stimulation and, consequently, dysfunction of this organ cannot be a factor.¹ The large amounts of free fatty acids in the intestinal contents bind calcium provided by the diet to form insoluble soaps. This mechanism in turn produces chronic calcium deficiency which in long-standing cases may be manifested by osteoporosis. The presence of split fats in the stools together with the absence of undigested starch granules and meat fibers suggest failure of absorption rather than failure of digestion. This is confirmed by the different results given by oral and intravenous glucose tolerance tests. The former yields a low flat blood sugar curve, while the latter gives a normal curve indicating normal carbohydrate metabolism. The light color of the stools is due to the presence of leucobilirubin.

Advanced multiple nutritional deficiencies have been shown to be associated with characteristic changes in the x-ray pattern of the small intestine after ingestion of the standard barium meal.¹² Similar changes occur in the small intestine in sprue indicating further the extensive dysfunction of this portion of the gastrointestinal tract.¹³

The diagnosis of idiopathic steatorrhoea and sprue is not difficult in view of the characteristic clinical picture, the character of the stools, the results of oral and intravenous glucose tolerance tests and the findings on x-ray examination of the small intestine.

Treatment, except in the far advanced case, is usually effective in producing remission and controlling progression and relapse. Until comparatively recently, the most effective regime consisted of a diet high in protein and low in fat together with adequate amounts of crude liver extract administered parenterally. Recently, vitamin B₁₂ and folic acid have been shown to be effective therapeutic agents in certain cases.¹⁸ Further studies of these preparations have shown that there are some patients with megaloblastic anemia who respond well to liver extracts, vitamin B₁₂, and folic acid; others, however, respond to folic acids but not to parenteral liver extracts or to vitamin B₁₂.⁸

Redundancy of the colon is one of the most frequent of the congenital anomalies of the lower bowel. It is said to be associated with approximately 22 per cent of cases of chronic constipation. As the name implies, the colon is unusually long and frequently dilated, particularly the pelvic

colon. It is accompanied by abdominal pain, constipation and flatulence. Treatment should be conservative and directed to restoration of normal colonic function without the use of cathartics.

Diverticula are more common in the colon than in any other portion of the intestinal tract. They are found in from 3 to 10 per cent of all patients x-rayed. Generally they are multiple, occurring predominantly in the iliac and pelvic areas but they may be present in the proximal colon and even in the cecum.

The pouches develop at the site of a congenital weakness of the wall usually between the leaves of the mesentery. Less commonly they occur on the antimesenteric border or in the appendices epiploicae. In some instances all four coats of the bowel wall are involved; in others only the mucosa, submucosa and serosa.

This condition, diverticulosis, is observed most frequently in stocky individuals past middle life. In uncomplicated cases they are no symptoms or merely some degree of functional instability of the colon. Constipation is frequent. Perhaps the most important aspect of treatment is recognition of frequency with which this condition occurs, the rarity of significant pathology and symptomatology, and the lack of indication for radical dietary or other treatment.

Chronic infections of the colon are likewise frequently encountered. They may be classified as bacterial, protozoal, helminthic, and non-specific. The prevalence of the different types varies in different parts of the world in accordance with local conditions of sanitation as these affect the possibility of fecal contamination of food, water and soil. The most important bacterial agents are the *Shigella dysenteriae*, the etiologic agents of bacillary dysentery, and various members of the *Salmonella* group. When these infections become chronic, the clinical results are little if any different from those of chronic ulcerative colitis.

Of the protozoa, the *Endamoeba histolytica* is by far the most important. Chronic infection by this organism occurs in at least 10 per cent of the population of the United States.⁵ In certain rural and institutional groups the prevalence has been shown to be as high as 38 per cent and 55 per cent, respectively.^{2,3} The writer has found this infection in over 30 per cent of veterans in North Carolina.¹⁴

Chronic amebiasis is rarely manifested by dysentery or acute diarrhoea. Much more common

is the syndrome of occasional brief periods of mild looseness followed by constipation or normal bowel function. These patients frequently are below par physically, often underweight and unable to gain weight. Vague abdominal pain and discomfort with flatulence are common complaints, and there is often intolerance of excess fat in the diet. It is not uncommon for such patients, after the possibility of chronic gallbladder disease is eliminated, to be labeled as instances of psychoneurosis; whereas, in fact, they are handicapped individuals who can easily be restored to normal health. Unfortunately, the diagnosis of intestinal amebiasis can be made only by the demonstration of the *Endamoeba histolytica* in the stools and this organism is frequently missed even by laboratory workers highly competent in other fields.

Ideally, treatment of this infection is by the combined use of emetine hydrochloride and diodoquin over the same eight-day period. Emetine, however, should not be administered to ambulatory patients because of its cumulative toxic action which is demonstrated by the not infrequent changes in the electrocardiogram during the period of therapy.

Parasitic worm infections producing significant chronic disease of the colon are fortunately rare in this country although frequently encountered in tropical regions.

Chronic ulcerative colitis is a distressing condition both for the patient and the physician because therapy is unsatisfactory in so many individuals. The etiology remains a matter of debate. Many microorganisms have been advanced as etiologic agents but none have met the criticisms levelled at them. Similarly, the high prevalence of psychoneurotic characteristics have led to the concept that emotional factors may play a primary role. Bockus and his associates¹⁶ found that all of the patients whom they studied revealed neurotic traits but concluded that there is no direct or specific etiologic relationship.

The disease is characterized by long chronicity, of course, with periods of exacerbation and remission, in many instances occurring spontaneously. Each period of activity is usually accompanied by further extension of the pathologic process and by progressive damage leading ultimately to extensive and permanent destruction of the mucous membrane, fibrosis of the bowel wall, polypoid degeneration, and shortening and narrowing of the colon. One of the important late complications

is the development of carcinoma which occurs in approximately 5 per cent of cases.¹⁷

Irrespective of the primary mechanism of the disease, studies of a group of patients continuing over a period of years have led the writer to the concept that in many instances, once the pathologic process is established, a complex set of actors become operative which act together to maintain the chronicity and to produce recurring periods of activity. These factors include secondary infection, primary or secondary malnutrition states and sensitization of the affected colon to foreign proteins originating from certain foods and certain micro-organisms.¹¹

It is inevitable that lack of certainty concerning the etiology should lead to the recommendation of a variety of therapeutic regimes. The extremes are represented by too long adherence to medical measures on the one hand, and immediate ileostomy on the other. A middle course is unquestionably the wisest one. In the absence of serious complications, these patients should be handled medically and carefully studied through at least one full cycle of the disease. The regime should be directed to the maintenance of optimal nutrition and to the attempt to identify certain of the etiologic factors which may be operative. Sensitization to specific food proteins plays a most important role in some cases. Identification of this mechanism, however, is difficult since skin tests are completely undependable and misleading. It is necessary to utilize the elimination diet technique applied with meticulous accuracy. When satisfactory evidence of food allergy is obtained, dramatic and long-standing improvement may follow, provided the necessary diet restrictions are followed permanently. In certain instances, also, autogenous vaccines seem to give some temporary benefit. It is doubtful that this is related to an immunity mechanism. It seems more probable that any improvement should be attributed to a temporary desensitization to certain bacterial proteins.

In advanced cases there is frequently dissociation of colonic motor function with prolonged delay in the proximal colon despite numerous evacuations which the patient may describe as diarrhea, but which, in fact, consist principally of mucus, pus and blood with little fecal matter. This condition is best handled by daily small doses of a mild saline, which, when properly adjusted,

will relieve spasm and pain and reduce the total number of evacuations.

Definitive surgical treatment may be required when medical measures fail. In the usual case, it implies permanent ileostomy and resection of the affected portion of the colon. The ideal management of chronic ulcerative colitis is, therefore, a complicated problem requiring the best judgment of the internist and the surgeon. The wisdom of ultimate surgery is pointed up by the incidence of carcinoma in long-standing cases.

Diverticulitis, fortunately, is as rare as the diverticula are common. It appears to be the result of the formation of fecal concretions in one or more diverticula, with ulceration and secondary infection. The symptoms and signs are those of an acute or chronic inflammatory process and may range from localized pain and tenderness with the presence of a mass, especially in the left lower quadrant, to abscess formation or to perforation and peritonitis. In the chronic recurring type fibrosis, thickening of the bowel wall and stenosis may be produced and require resection. Similarly, the acute form may urgently call for operative intervention. In the milder cases the primary indication for treatment is the control of constipation. The condition variously designated simple colitis, irritable colon, spastic colon or mucous colitis is one of the most common conditions encountered in the whole field of gastroenterology. It is seen in approximately 40 per cent of all patients having abdominal disorders.⁹ It is a functional disturbance and not an inflammatory disease. It is characterized by abdominal discomfort or pain frequently appearing immediately after eating and due, apparently, to an abnormally active gastro-colic reflex mechanism. Diarrhea or constipation with abnormal amounts of mucus in the stools is usual, and there is frequently the complaint of faintness at stool. The severity of the symptoms tend to vary directly with fatigue and emotional strain.

One of the most striking features of this condition is the disparity between the subjective phenomena and the objective findings. Apart from variable tenderness over the colon, physical examination of the abdomen commonly reveals nothing of note. X-ray examination, however, is both useful and important. The essential findings are hypermotility with the barium meal reaching the pelvic colon within nine hours, and demonstration by barium enema of exaggerated haustration, or

narrowing with loss of haustra in the descending colon.

One of the most important aspects of treatment is continued reassurance of the patient and re-education to control the anxiety and neurotic factors. Of equal importance is the establishment of normal evacuation without catharsis and insistence upon discontinuing the frequent practice of high irrigations and repeated enemas.

The colon is one of the most important sites of tumor formation in the body. Benign tumors, usually adenomatous polyps, are relatively common. Approximately 45 per cent of them occur in the sigmoid and rectum.⁷ They are frequently asymptomatic but may be responsible for rectal bleeding, prolapse, or obstruction. More important, however, is the fact that about 10 per cent undergo malignant degeneration.

Carcinoma is the most common malignant tumor, and carcinoma of the rectum is said to be fifth in the list of frequency of primary carcinomas. It is somewhat more common in males than in females and there is a tendency for it to appear before the "cancer age." About 5 per cent of rectal carcinomata occur in patients under the age of thirty.

There are no characteristic or pathognomonic symptoms prior to the advanced stages of the disease when metastasis has almost certainly occurred and when cure is improbable. Generally, the clinical picture is that of slow and insidious alteration of bowel habit which may not attract particular attention. With enlargement of the tumor mass, narrowing of the stools may be noted; and as ulceration occurs, blood in variable amounts appears in the stools. When relative obstruction of the colon develops, there may be pain, nausea and vomiting. It is important to remember that more than 75 per cent of all rectal cancers can be felt by digital examination of the rectum when the patient is in the left lateral position with the knees drawn up.

In no other form of internal cancer can such good results be obtained, if only the diagnosis is made before the process has extended beyond the bowel wall. Thus, Lahey¹⁰ has reported that 90 per cent of cases of rectal carcinoma were free from disease five years after operation when no metastases were demonstrable at the time of the resection. When the lymph nodes were involved, the five-year prognosis was reduced by almost two-thirds.

Too frequently obvious hemorrhoids are accept-

ed as adequate explanation of rectal bleeding and, consequently, thorough examination is omitted. In such instances tragedy frequently results. Too much emphasis cannot be placed on the axiom that the passage of blood by rectum is an imperative indication for the application of all the diagnostic measures which are of use in establishing with certainty the exact nature of the underlying pathology.

Patients with gastrointestinal disease commonly consult the family physician rather than the specialist, particularly in the early stages. The variety of pathologic conditions affecting the intestinal tract and the differing prognoses in many of these diseases, when diagnosis is delayed, emphasize the responsibility resting upon the practitioner of internal medicine. The complicated and often atypical symptomatology too frequently are ascribed to emotional factors, and the resulting diagnosis of psychoneurosis may cloak the progression of organic disease until cure becomes impossible. The numbers of patients seeking assistance for the relief of symptoms referable to this physiologic system emphasize the necessity for an adequate working knowledge of the mechanism underlying symptoms arising from the intestinal tract, and of the more important methods of examination upon which final differential diagnosis must be based.

Bibliography

1. Comfort, M. W.; Dornberger, G. R.; Wollaeger, E. E., and Power, M. H.: External pancreatic secretion as measured by the secretin test in patients with idiopathic steatorrhoea (nontropical sprue). *Gastroenterol.*, 13:135-140 (Aug.) 1949.
2. Craig, C. F.: *Amebiasis and Amebic Dysentery*. Springfield, Ill.: Charles C Thomas, 1934.
3. Craig, C. F., and Faust, E. C.: *Clinical Parasitology*. 5th Ed. Philadelphia: Lea & Febiger, 1951.
4. Crohn, B. B.; Ginzburg, L., and Oppenheimer, G. D.: Regional ileitis: A pathologic and clinical entity. *J.A.M.A.*, 99:1323-1329 (Oct. 15) 1932.
5. Faust, E. C.: The prevalence of amebiasis in the western hemisphere. *Am. J. Trop. Med.*, 22:93-105 (Jan.) 1942.
6. Greenblatt, R. B.; Pund, E. R., and Chaney, R. H.: Meckel's diverticulum: Analysis of eighteen cases, with report of one tumor. *Am. J. Surg.*, 31:285-293, 1936.
7. Helwig, E. B.: Benign tumors of the large intestine: Incidence and distribution. *Surg., Gynec. & Obst.*, 76:419-426, 1943.
8. Israels, M. C. G., and Sharp, J.: Idiopathic steatorrhoea (non-tropical sprue) with megaloblastic anemia. *Lancet*, 1:752-757 (April 22) 1950.
9. Kantor, J. L., and Kasich, A. M.: *Handbook of Digestive Diseases*. 2nd Ed. St. Louis: The C. V. Mosby Co., 1949.
10. Lahey, F. H.: Selection of operation and technic of abdominal perineal resection for carcinoma of the rectum. *S. Clin., North America*, 26:528-552, 1946.
11. Mackie, T. T.: Studies in ulcerative colitis. *Tr. & Studies, Coll. Physicians, Philadelphia*, 9:1-10 (Apr.) 1941.
12. Mackie, T. T., and Pound, R. E.: Changes in the gastrointestinal tract in deficiency states. *J.A.M.A.*, 104:613-618 (Feb. 23) 1935.
13. Mackie, T. T.; Miller, D. K., and Rhoads, C. P.: Sprue: Roentgenologic changes in the small intestine. *Am. J. Trop. Med.*, 15:571-589 (Sept.) 1935.
14. Mackie, T. T.; Tuttle, R. L., and Simpson, T. W.: Amebiasis in civilian hospital and veteran patients in North Carolina. *So. M. J.*, 43:313-319 (Apr.) 1950.
15. Mason, E. F.; Kridelbaugh, W. W., Couch, W. H., and Ward, M.: Streptomycin in the treatment of tuberculous enteritis; a report of thirty-three cases. *Am. J. M. Sci.*, 217:28-46 (Jan.) 1949.
16. Mahoney, V. P.; Bockus, H. L.; Ingram, M.; Handley, J. W., and Yaskin, J. C.: Studies in ulcerative colitis: I. A study of the personality in relation to ulcerative colitis. *Gastroenterol.*, 13:547-563 (Dec.) 1949.
17. Sloan, W. P.; Bagen, J. A., and Bagenstoss, A. H.: Local complications of chronic ulcerative colitis based on the study of 2,000 cases. *Proc. Staff Meet., Mayo Clin.*, 25:240-244 (May 10) 1950.
18. Spies, T. D., and Suarez, R. M.: Response of tropical sprue to vitamin B₁₂. *Blood*, 3:1213-1220 (Nov.) 1948.

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HEADACHES

(Continued from Page 707)

18. O'Sullivan, M. E.: Termination of one thousand attacks of migraine with ergotamine tartrate. *J.A.M.A.*, 107:1208 (Oct. 10) 1936.
19. Ray, B. S., and Wolff, H. G.: Experimental studies on headaches: Pain-sensitive structures of the head and their significance in headache. *Arch. Surg.*, 41: 813 (Oct.) 1940.
20. Simons, D. J., and Wolff, H. G.: Studies on headaches: Mechanisms of chronic posttraumatic headache. *Psychosom. Med.*, 8:227 (July-Aug.) 1946.
21. Wolff, H. G.: *Headache and Other Head Pain*. New York: Oxford University Press, 1948.
22. Wolff, H. G.: Headache. In MacBryde, C. M.: *Signs and Symptoms: Their Clinical Interpretation*. p. 14. Philadelphia: L. B. Lippincott Company, 1947.

FEDERAL LEGISLATION

(Continued from Page 684)

tion laws. The bill (H.R. 5678) introduces a high degree of "selectivity" in choosing between applicant immigrants. The first 50 per cent of the quota of each country annually would be made available to qualified quota immigrants whose services are determined by the Attorney General to be needed urgently in the United States because of the high education, specialized experience, or exceptional ability of such immigrants, and to be substantially beneficial to the national economy, cultural interests, or welfare of the United States. This group of skilled persons (including physicians) and their families would be given preference over alien parents of citizens of the United States and qualified quota immigrants who are spouses or children of aliens lawfully admitted for permanent residence in the United States. Unfilled quotas from other than the skilled person group could also be used to admit persons in the skilled category.

Acute Abdominal Conditions

By Charles R. Doyle, M.D.

St. Louis, Missouri

ACUTE ABDOMINAL conditions are of diagnostic and therapeutic interest to almost the whole field of medical practitioners, and there are no limitations or boundaries for specialists alone. General practitioners, internists, surgeons, even dermatologists and neurologists may be concerned with the diagnosis and often with the treatment of an abdominal emergency.

There is nothing new, startling or dramatic about this subject. Great practitioners of the past have written volumes about it. Now there are new and more accurate laboratory tests which tend to play a more and more important part in the differential diagnosis. However, keeping in mind certain anatomical and physiological facts will simplify reaching the proper diagnosis and expedite the indicated treatment.

The term "acute abdominal condition" embraces a great many clinical entities, but ordinarily only a half-dozen or so are confused with others.

An acute abdominal condition is the most important everyday disorder requiring early diagnosis so that the proper treatment may be implemented. This is true because an incorrect diagnosis and plan of treatment may result in complications which unduly prolong the illness, permanently incapacitate the patient, or even cause death. In any event, there is frequently an economic, as well as a physical, catastrophe if the diagnosis is wrong.

The exact cause of an acute abdominal condition is not nearly as important as deciding what should be done. Valuable time may be lost in trying to be too exact, which results in prolonged indecision and vacillation so that, literally, the patient is examined to death. It is true that incomplete investigation may cause a wrong diagnosis, but it does not follow that it is necessary or desirable to order every laboratory examination which possibly could apply. This is not only time consuming but often the determinations are overlap-

ping, and the cost is no small item. Other causes of wrong diagnoses are: preconceived ideas (a pitfall of the inexperienced), failure to think anatomically and physiologically, incomplete history taking and poor physical examination.

This subject cannot be discussed without repeating the oft-stated fact that the history and physical examination are most important. Laboratory determinations, including x-ray examinations, are important, too, but their value in the majority of acute conditions is chiefly corroborative. There is too often the tendency of some to approach the problem of the abdominal emergency by ordering many laboratory tests and various x-ray examinations in the hope that the correct answer will be forthcoming automatically.

The foregoing statements are not intended to depreciate the value of these important ancillary procedures in any way, but rather to condemn the practice of abusing the laboratories by overloading them with requests for emergency determinations which frequently have little bearing on the immediate problem and, too often, are completely ignored when reported.

There is no substitute or shortcut for the information obtained through the careful bedside examination of the patient. The thorough clinician gains his facts by observation, palpation, percussion and auscultation of the abdomen—also, by that oft-neglected, digital rectal or vaginal examination. The consideration of these findings with the history and the results of the indicated laboratory tests constitutes the only sound basis for a correct diagnosis. The proper evaluation of all information, particularly the exclusion of "red herrings" depends on the very significant faculty called clinical judgment.

Pain and changes in bowel activity are practically always present where there is an acute abdominal condition. Study of these two factors will very often clearly indicate the probable diagnosis.

The type of onset, character, location and referred distribution of the pain must be determined.

Changes in bowel activity can be obtained from the history and by listening to the abdomen with the stethoscope. The stethoscope is a very important diagnostic instrument in abdominal, as well as in pulmonary and cardiovascular, conditions.

The application of this information is indicated by the following outline, which, of course, serves only as a general guide:

Presented at the eighty-sixth Annual Session of the Michigan State Medical Society, Grand Rapids, September 26, 1951.

I. ABDOMINAL PAIN

A. Sudden Onset

1. Producing fainting
 - (a) Men: Perforated peptic ulcer
 - (b) Women: Also ruptured ectopic gestation
2. Not producing fainting
 - (a) Colics (associated with restlessness)

Intestinal	Ureterorenal
Biliary	Uterine-tubal
Pancreatic	
 - (b) Hemorrhage

Spleen	Kidneys
Liver	Bladder
Intestines	Ruptured aneurysm
Cysts (ovarian, pancreatic, mesenteric)	
 - (c) Emboli, thrombosis and infarction

Mesentery	Liver
Spleen	Iliac vessels

B. Insidious Onset

1. Inflammatory lesions
 - (a) Becoming obstructive

Appendicitis	Salpingitis
Cholecystitis	Regional ileitis
Acute hydronephrosis or pyelitis	
Diverticulitis (Meckel's or colon)	
 - (b) Not obstructive

Acute gastroenteritis	Acute cystitis
Ulcerative colitis	Pancreatitis
Mesenteric lymphadenitis	Peritonitis

 (Movement increases pain)
2. Neoplasms
3. Post-trauma
4. Abscesses

C. Location

1. Usually over the affected organ
2. Radiation to top of shoulder (either supraspinous fossa, over acromion, over clavicle or in subclavicular fossa)
 - (a) Cholelithiasis (radiating from right subscapular area)
 - (b) Ruptured spleen (left)
 - (c) Subphrenic abscess
 - (d) Perforated peptic ulcer
 - (e) Diaphragmatic pleurisy
 - (f) Acute pancreatitis (radiates from mid-line back)
 - (g) Liver abscess
 - (h) Appendicitis with generalized peritonitis
3. Colics
 - (a) Small intestinal

Epigastric and umbilical (T_9 to T_{11})
--
 - (b) Large intestinal

Hypogastric (T_{11} to L_1)

 - (c) Biliary

Right subcostal radiating to subscapular area (T_8)

 - (d) Renal

Loin, radiating to corresponding testicle (L_1, L_2)
--

4. Referred cutaneous hyperesthesia

- (a) Present in one-half the cases of acute abdominal condition
- (b) May be referred to skin level of same spinal nerve innervating the pathologic organ

II. BOWEL CHANGES

- A. Peristaltic sounds usually decreased or absent, with obstipation
 1. Peritonitis (paralytic ileus)
 2. Intra-abdominal hemorrhage
- B. Peristaltic sounds usually increased, without diarrhea
 1. Mechanical obstruction (tinkles and rushes sometimes audible)
- C. Peristaltic sounds usually increased, with diarrhea
 1. Acute gastroenteritis
 2. Dysenteries
- D. Hypogastric pain and diarrhea followed by hypogastric tenderness and constipation are suspicious of a pelvic abscess and/or pelvic appendicitis
- E. Bloody or tarry stools with acute abdomen indicate intragastrointestinal hemorrhage

There are a few generalities which should be kept in mind:

In a previously well patient, severe abdominal pain of more than four hours' duration usually indicates surgical intervention.

If the temperature is 104° to 105° early, the pathologic process is probably not in the abdomen.

An acutely inflamed appendix lying in the pelvis causes little, if any, abdominal wall rigidity.

Movement and pressure increase pain in peritonitis.

Laboratory procedures are diagnostic aids which must be used intelligently by the clinician.

≡ MSMS ≡

GOVERNMENT COSTS

Why does Government cost more? Here's a clue:

The Declaration of Independence contains 300 words; the Ten Commandments contain 297 words; the Lord's Prayer contains fifty-six words; the two Commandments that comprise the whole law of God contain twenty-three words.

But despite the examples of simplicity and brevity set by these masterpieces of wisdom and literature, the OPS order setting the price of cabbage contains 26,911 words.

Diabetic Coma

Prevention and Treatment

By Alexander Marble, M.D.

Boston, Mass.

IN THE twenty-nine years which have elapsed since the introduction of insulin into clinical use, the morbidity and mortality from diabetic coma have decreased markedly. Prior to 1922, from 40 to over 60 per cent of diabetics who died, did so in diabetic coma.⁵ At present, less than 2 per cent of deaths among diabetics are in coma.⁴ However, this means that significant numbers of patients still acquire, and still die from, this acute complication which is the end result of poorly controlled diabetes. Further improvement is possible and is urgently needed.

In certain hospitals in recent years a zero or near zero mortality has been achieved over many months of time. Harwood³ reported recently that at the Massachusetts General Hospital between November, 1944, and July, 1951—over six and one-half years—there were only two deaths from diabetic coma among seventy-five consecutive cases. This contrasts sharply with a mortality of 20 per cent among thirty-five cases at the same hospital from January, 1942, to November, 1944. Harwood ascribes this remarkable improvement to changes which can be made in any hospital: constant stimulation and training of the house staff to give more aggressive treatment, including truly large doses of insulin, beginning immediately upon admission to the hospital; insistence upon the active and personal interest of the visiting staff with immediate consultation when coma cases appear; and arrangements so that complete laboratory service may be had at any hour, day or night, Sundays or holidays. From another institution, the Pennsylvania Hospital, Duncan et al² reported no deaths from diabetic coma in two and one-half years. Our own experience at the New England Deaconess Hospital has been much the

same. From April, 1945, to May, 1948, there were ninety-two consecutive cases without a death. Pride came before a fall, however, because in 1948 within a five-month period there were four deaths. However, from November, 1948, to July 1, 1951, there have been sixty-seven consecutive cases with only one fatality.

In Table I are summarized data regarding 805 cases treated at the New England Deaconess Hospital from May, 1923, to July 1, 1951. In all patients the carbon dioxide content (in earlier years the carbon dioxide combining power) of the blood plasma was 9 m. eq. per liter or less (20 volumes per cent or less). It will be noted that the average patient was 29.3 years of age and had had diabetes for 6.2 years at the time of coma. There were sixty-six deaths making an over-all mortality of 8 per cent. However, in the 342 cases of coma since January, 1940 (Series III and IV), the mortality fell to 3 per cent.

The five deaths in 1948 and 1949 were needless insofar as diabetic coma was concerned and certainly demand explanation. In Table II is given certain information regarding these five patients. It is evident that three of the patients had serious complications.

Case 1.—A man, aged seventy-two years, whose diabetes had been discovered less than three weeks before admission in coma, received 1800 units of insulin within the first sixteen hours in the hospital but died thirty-nine hours after admission. An electrocardiogram suggested a posterior myocardial infarction. During the first few hours in the hospital he developed a right hemiplegia. Permission for a postmortem examination was not obtained.

Cases 2 and 3.—These two patients each died in about thirteen hours after admission despite a total of 992 and 2300 units of insulin respectively. On admission the former had a blood sugar of 1075 mg. and the latter of 1525 mg. per 100 cc. This patient Case 32266 had been in the New England Deaconess Hospital for over two months earlier in the year because of profound and long-continued hypoglycemia due to insulin overdosage from which irreversible cerebral damage resulted. Case 23088 had been unconscious for fourteen hours prior to admission. On admission 50 cc. of urine were obtained by catheterization but during the entire period of thirteen hours in the hospital she was almost totally anuric. In neither of these patients was permission for a postmortem examination obtained.

Case 4.—A woman, aged 59.3 years, with diabetes of 8.3 years' duration, was found at postmortem examination to have a chronic and acute pyelonephritis of severe grade with numerous cortical abscesses and peri-

Presented at the Eighty-sixth Annual Session, Michigan State Medical Society, Grand Rapids, September 27, 1951.

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DIABETIC COMA—MARBLE

TABLE I. DIABETIC COMA
805 CASES

Series	No. of Patients	Date	Age of Patient* Years	Duration of Diabetes* Years	Fatal Cases	
					Number	Per Cent
I	179	May 1923 to Aug. 1931	30.9	3.2	27	15
II	284	Aug. 1931 to Jan. 1940	29.1	4.6	28	10
III	188	Jan. 1940 to Jan. 1946	27.9	6.3	6	3
IV	154	Jan. 1946 to July 1, 1951	31.1	9.3	5	3
Totals and Averages	805		29.3	6.2	66	8

*Average figures at time of diabetic coma.

TABLE II. SUMMARY OF DATA REGARDING FIVE FATAL CASES OF COMA

Case	Clinic Case Number	Sex	Age at Coma Yrs.	Duration of Diabetes Yrs.	Findings on Admission				Insulin		Survival in Hosp. Hrs.	Complications
					Blood Sugar Mg./100cc.	Plasma CO ₂ m.eq./l.	B. P. mm. Hg.	Blood NPN Mg./100cc.	First 3 hrs. Units	Total 24 hrs. Units		
1.	32877	M	72.0	0.4	835	9	104/54	65	200	1800	39	Rt. hemiplegia ? myocardial infarction
2.	32266	F	27.1	7.2	1075	4	76/20	45	400	900	13	—
3.	23088	F	47.3	14.3	1525	4	70/54	105	1200	2300	13	—
4.	33704	F	59.3	8.3	400	7	92/58	49	200	230	10	Chronic and acute pyelonephritis Extensive broncho- pneumonia
5.	20454	M	40.8	8.7	790	8	90/50	66	500	1050	26	

nephric infection on the left. It will be noted from Table II that she received only 200 units of insulin in the first three hours after admission and a total of only 230 units during the ten hours of life in the hospital. Prior to admission she had received at home her usual dose of 20 units of protamine zinc insulin at 8:00 A.M. and had been given an additional 30 units of unmodified insulin at 11:00 A.M., three and a half hours prior to admission. The blood sugar on admission was 400 mg. per cent and the plasma CO₂ 7 m.eq. per liter. With the amount of insulin given, the blood sugar fell quite satisfactorily to 222 mg. per cent at three hours after admission and a similar value was obtained at six and a half hours after admission. On the latter occasion the urine was found to be free from diacetic acid and the plasma CO₂ had risen to 13 m. eq. per liter. Although the patient continued to be confused and irritable, her progress seemed reasonably satisfactory and her sudden death ten hours after admission was unexpected. In reviewing this patient's history it was noted that her present illness had actually begun fourteen days before, at which time she had been admitted to another hospital because of nausea, vomiting and fever. She had been treated for pneumonia with penicillin and streptomycin. She had been discharged from this other hospital two days prior to admission to the New England Deaconess Hospital but had not been well, had had a poor appetite and had gradually become worse, developing back pain. In retrospect it would appear that this patient died from long-continued and overwhelming sepsis. Studies regarding the potassium content of the blood were not made, but it appears unlikely that these would have been revealing or helpful.

Case 5.—A man, aged 40.8 years, died twenty-six hours after admission despite 1050 units of insulin. Post-mortem examination confirmed the diagnosis of bilateral

bronchopneumonia and showed this to be so extensive as to leave very little functioning lung tissue. A second complication during the course of coma was oliguria progressing to anuria. This patient prior to hospital admission had been markedly drowsy for sixteen hours and in the latter ten hours of this period had been totally unconscious.

* * *

In retrospect, it is difficult to state what change in treatment might have brought about recovery in these five patients. Study of the case histories does not suggest that the deaths were related to potassium deficiency. As has been described, they were all patients who had serious complications or who had been totally unconscious in diabetic coma for many hours. One must concede that eventually irreversible changes are brought about in the central nervous system in diabetic coma and there comes a time eventually when therapy, however energetic, will be of no avail. Experiences such as this lend emphasis to the teaching that diabetic coma must be prevented if possible but that if it occurs, it must be diagnosed and treated early and vigorously.

Prevention of Diabetic Coma

Prevention of diabetic coma is all-important and may be accomplished by early and continuous education of the patient, his family and the general public. At the very start of treatment the patient should become familiar with the nature of diabetes, the important points in treatment and the prevention of complications, including acidosis. The patient should be imbued with the ideal of

the sugar-free urine and taught so effectively that he will not later fall a prey to those who advocate free and easy methods of treatment. To condone hyperglycemia and glycosuria is to tolerate a condition only one step removed from acidosis. The patient should be taught to test the urine frequently and to report difficulties and illnesses promptly to his physician. He should learn never to omit insulin, even when nauseated and vomiting, unless the urine is free from sugar at tests taken every few hours. The patient must appreciate that in the presence of infection, particularly with fever, and in the presence of certain other complications, the insulin requirement may be increased temporarily. Therefore, in infections, urine tests must be done at frequent intervals and additional insulin taken if necessary. All too often patients omit insulin during times of acute illness when food intake is scant or nausea and vomiting are present. Fearing hypoglycemia from overdosage with insulin, the patient reasons that if he is not eating, he should not take insulin. The consequence may be increasing hyperglycemia with later the development of ketosis and eventual coma.

Development of Diabetic Coma

There is great variation from patient to patient but in general the symptomatology of well-marked diabetic coma develops along the following lines:

1. Early symptoms such as polydipsia and polyuria due to inadequately controlled diabetes;
2. Digestive symptoms, including anorexia, nausea, vomiting and later abdominal pain.
3. Respiratory symptoms with air hunger (Kussmaul) type of respiration characterized by long, deep, rapid breathing.
4. Central nervous system involvement with drowsiness progressing to unconsciousness.
5. Circulatory involvement leading to collapse with weak, rapid pulse, low blood pressure, subnormal body temperature and cold, mottled extremities.

It must be emphasized, however, that the symptoms of diabetic ketosis, particularly the early and the terminal symptoms, may be vague, variable and atypical. The physician must be ever on his guard when confronted by any abnormal turn of events in a diabetic.

The developments noted above take place because of an acute deficiency of insulin. This arises

not only in the patient who omits his insulin or breaks his diet or both but also innocently in the individual with hitherto unrecognized diabetes. Furthermore, coma may be precipitated by influences outside the pancreas, such as infections, thyrotoxicosis and menstruation, but the end result is the same, namely, gross inadequacy of insulin effect for the individual at the time concerned. Because of insulin lack, carbohydrate stores become low and utilization is impaired. Greater recourse is had by the body to fats. Consequently, acetone bodies are formed in amounts larger than can be used peripherally and therefore accumulate in the blood and body fluids and are excreted in the urine.

The body can withstand a certain increase in the ketone acids by excreting them as free acid in highly acid urine or by neutralization with ammonia followed by excretion. A considerable amount of the ketone acids may yield to the buffer action of the blood bicarbonate and the blood proteins, thereby preventing significant change in the blood pH. However, if these natural defenses are overwhelmed, the body must resort to neutralization of the ketone acids with fixed base, chiefly sodium, and excretion in the urine. Other electrolytes lost from the body either by vomiting or by excretion in the urine include potassium, phosphates and chlorides. The end results are: (1) depletion of fixed base, chloride and phosphate of the body; (2) lowering of the plasma CO_2 content and shift in the pH of the blood toward the acid side; (3) hemoconcentration and dehydration and (4) depletion of glycogen stores in liver and muscles.

Treatment of Diabetic Coma

In planning treatment one must keep in mind the following objectives: (1) to replace the insulin deficit promptly; (2) to correct dehydration; (3) to prevent or treat chemical abnormalities such as a low serum potassium, low plasma chloride and blood nitrogen retention; (4) to discover and treat complications.

It is the physician's serious responsibility to make the diagnosis early and to institute vigorous treatment promptly. In a known diabetic with a classical history, given by relatives, the diagnosis may be easy. In an unconscious, unidentified patient brought without relatives or friends to the emergency ward of a large city hospital, the recognition of the condition may be more difficult.

However, diagnosis will depend chiefly on keeping the condition in mind. At times in the known diabetic there may be difficulty in differentiating between unconsciousness due to hypoglycemia and to diabetic coma. Consequently the differential diagnosis between these two conditions must be familiar to the physician and, in case of doubt, laboratory aid must be sought without hesitation and at once. A few minutes or an hour or two may make the difference between life and death.

The patient in diabetic coma belongs in a hospital. Success in treatment depends upon attention to details and upon close continuous attention of physicians and nurses. Immediately upon arrival an adequate history and physical examination should be made expeditiously. The urine, obtained by catheter if necessary, should be tested at once for sugar and diacetic acid. Blood should be drawn for the determination of sugar, CO_2 content, nonprotein nitrogen and such other constituents as may appear indicated. A trained technician always on call in the laboratory should begin the analyses at once and be prepared to give a report regarding the blood sugar and CO_2 in at least an hour and preferably in forty-five minutes. However, one does not wait to learn the results of the blood analyses before starting treatment. If the history, physical findings and urine tests are characteristic, one should proceed without delay with the giving of insulin and fluids.

Diabetic coma is primarily a state of acute deficiency of insulin. Other measures in treatment, however admirable, will be futile unless enough insulin is given. Moreover, to insure maximum success, large amounts must be given early, that is, within the first two or three hours of treatment. In the adult patient with full-blown coma, often several hundreds of units of insulin will be necessary. The initial dose given a few minutes after admission may well be 100 units subcutaneously with an additional 100 units intravenously with patients in circulatory collapse. At one hour after admission when the results of the blood sugar and CO_2 determinations are available, additional insulin may be given as follows:

If the initial blood sugar is—

300- 600 mg. per 100 cc. give 50 to 200 additional units
600-1000 mg. per 100 cc. give 200 to 300 additional units
Over 1000 mg. per 100 cc. give 300 to 400 additional units

Often more insulin is indicated at the second hour after admission. It must be emphasized that

treatment cannot be made routine but must be individualized and altered to suit changing needs. The blood sugar should be obtained at first every two to three hours.

The first three to six hours of treatment must be viewed as an attempt to stage an overpowering onslaught in the battle against the acute acidosis. In the presence of acidosis, insulin must be regarded as one does paper money in times of inflation, gauging the amount used not according to normal standards but by the effect secured. Following the giving of large amounts of insulin initially, subsequent needs during the first eighteen to twenty-four hours may be judged by blood and urine tests at appropriate intervals.

It goes without saying that care and judgment must be used in deciding as to the amount of insulin to give in any individual case. Children usually require much smaller doses than adults. Patients with diabetes of recent onset who have never received insulin before may respond more readily than those with well-established diabetes who have been taking insulin. Finally, those patients with less severe acidosis usually require less insulin.

The second important matter in the treatment of diabetic coma is the overcoming of dehydration with fluid and replacement of lost electrolytes. During the development of acidosis various electrolytes have been lost from the body: sodium, chloride, potassium, phosphorus, calcium, magnesium, et cetera. Some have tried and are trying complex solutions containing varying proportions of these elements.¹ These attempts to improve therapy are to be encouraged since the thought is logical and sound. However, although everyone recognizes that physiological solution of sodium chloride does not offer complete replacement of lost electrolytes and may provide a temporary excess of sodium and chloride, in practical usage it works out very well indeed to use this solution for intravenous administration during the first few hours of treatment. For most physicians this readily available solution is at present the best and safest to use. One may start an intravenous infusion of salt solution shortly after admission and continue this until 2,000 to 5,000 cc. and occasionally more have been given, gauging the amount by the degree of previous dehydration and the general condition of the patient.

Other points in treatment deserve mention. Since the stomach is often dilated, it is well to

carry out gastric lavage routinely shortly after admission, thereby relieving distention and paving the way for the early institution of oral feedings. The patient should be kept warm but this is better done by means of blankets rather than by hot water bottles or electric pads because of the danger of burning the patient. Blood transfusion is only occasionally indicated. Stimulants such as adrenalin and caffeine rarely are of real value. Of prime importance, however, is the beginning of oral feedings as soon as possible. This can often be done within 5-6 hours after the beginning of treatment although at times nausea and vomiting may continue and preclude such. Continued vomiting suggests the need of repetition of gastric lavage. When oral feedings are begun, these are at first of water and this is followed by broths, gruel, orange juice, tea with sugar and gingerale. By this means, valuable electrolytes, including potassium, are automatically offered to the body.

In recent years much has been said and written regarding the behavior of potassium in diabetic coma.⁶ Although when the patient is first examined, the blood potassium may be high, it is artificially so because of hemoconcentration. As hydration proceeds and as recovery takes place the blood potassium falls and may reach a truly low point 8 to 18 hours after treatment has been started. If it reaches a certain critical level, 2.5 to 3 m. eq. per liter or below, weakness progressing to muscular paralysis, including respiratory paralysis, may take place and rarely cause fatal issue. The level of the blood potassium may be followed by actual determinations using the flame photometer if such is available. If not, a rough idea may be obtained from serial electrocardiograms although these are by no means infallible. Rarely will clinical symptoms of hypokalemia develop if one avoids the use of glucose intravenously during the first hours of treatment and if one starts oral feedings early as described above. Potassium solutions may be given more safely by mouth than by vein. Particularly if they are given intravenously, one should be certain that renal function is adequate because hyperkalemia may prove fatal by causing cardiac arrest. For a discussion of types and concentrations of solutions for intravenous use, see the articles by Butler¹ and Martin, Hillier and Wertman.⁶

Glucose should not be given during the early hours of treatment. The glucose which is already flooding the blood and body fluids is just as serv-

iceable as any glucose which one can inject. To inject still more is to add insult to injury. Glucose is metabolically inert until it can be normally phosphorylated and this cannot take place until adequate amounts of insulin have been given. As noted above, the overgenerous use of glucose may favor the development of a low serum potassium since in the deposition of glucose as glycogen, potassium accompanies glucose and goes from the blood into fixed tissue cells. If glucose is being infused it is difficult to use the blood sugar level as a guide to the amount of insulin to be given. Finally, the use of glucose detracts attention away from the all-important matter of giving enough insulin. However, after large amounts of insulin have been given and the blood sugar has fallen satisfactorily, glucose may then be given parenterally if necessary, though rarely is there need.

The use of sodium bicarbonate is unnecessary and in some cases potentially harmful. The use of alkalis attempts to treat acidosis by striking at the effects rather than the cause of the abnormal condition and by decreasing rapid breathing may lead to a false sense of security. Sodium lactate offers certain advantages but with it, as with sodium bicarbonate, there is danger in overdosage.

In the successful treatment of diabetic coma, constant personal attention of the physician and the fearless use of insulin in adequate dosage are all important. No patient should die in or from diabetic coma unless there exists an acute complication which in itself is fatal. Deaths due to the fact that patients are not brought for treatment until they are moribund can in time be reduced in number or avoided by continuous education of the patient and his family from the day of diagnosis. A death in diabetic coma is a needless death.

References

1. Butler, A. M.: Diabetic coma. *New England J. Med.*, 243:648-659 (Oct. 26) 1950.
2. Duncan, G. G.; Carev, L. S., and Hudson, M. T.: Diabetic coma. *M. Clin. North America*, 1537-53 (Nov.) 1949.
3. Harwood, R.: Diabetic acidosis. *New England J. Med.*, 245:1-9 (July 5) 1951.
4. Joslin, E. P.: Thoughts upon diabetes today. *Rev. Gastroenterol.*, 17:545-551 (July) 1950.
5. Joslin, E. P.; Root, H. F.; White, P.; Marble, A., and Bailey, C. C.: *Treatment of diabetes mellitus*. 8th Ed., p. 421. Philadelphia: Lea and Febiger, 1946.
6. Martin, H. E.; Hillier, P., and Wertman, M.: Potassium deficits in diabetic acidosis with particular reference to problems in therapy. *Proc. Am. Diabetes Assn.*, 10:161-179, 1950.

The Treatment of Alcoholism in an Out-patient Clinic

By Frank A. Cellar, M.D., and
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THE Outpatient Clinic of the Detroit Committee on Alcoholism was established in April, 1950. It was anticipated that this facility might serve as a model for a statewide approach to the wider treatment of this disease. The purpose of the present paper is (a) to review the history of the organization of the Clinic; (b) to outline the rationale of the clinical treatment of alcoholism; (c) to describe the treatment methods currently used, and (d) to suggest a tentative evaluation of the results obtained with the first 444 patients.

The Clinic was started through the efforts of public spirited individuals and with funds contributed by the Detroit United Foundation. The Detroit Committee on Alcoholism has two major functions: education and treatment. Although we realize the great importance of the educational program for prevention as well as treatment, we are limiting our present discussion to the treatment aspects of the problem. (The educational program of the Detroit Committee on Alcoholism is supervised by an educational director who is responsible also for administrative duties at the Clinic).

The treatment program, which is a function of the Outpatient Clinic, is headed by a medical director. The staff consists of a psychiatrist and an internist who work on a part-time basis; and a clinical psychologist and a psychiatric social worker who serve full time. Only since January 1, 1951, has the staff been complete.

The Clinic deals primarily with a group in which drinking has interfered with social, economic, or marital adjustment. Since we treat individuals on an outpatient basis, we do not deal except in a limited way with psychotic or other severely disturbed groups, nor do we treat non-ambulatory patients.

From the Departments of Psychiatry and Medicine of Wayne University College of Medicine, Detroit, Michigan.

Study based on the first year's experience of the Outpatient Clinic of the Detroit Committee on Alcoholism.

The alcoholic group treated here uses alcohol to allay anxiety and tension, and in an attempt to solve their own emotional problems. Because of the personality structure implied by this behavior, and because of possible physiological disorders which are not well understood at present, the individual's life pattern becomes organized—and disorganized—in terms of his drinking.

Therapeutic procedures are based upon the conception of alcoholism as a syndrome consisting of a prodromal phase, a critical phase, and a chronic phase.² The prodromal phase includes excessive drinking without loss of control; individuals in this stage may have had brief retrograde amnesic episodes as a result of drinking ("blackouts"), and liquor has assumed increasing importance in their lives. The critical phase includes the loss of control over how much is drunk at a given time, and at what time the drinking will occur; this loss of control is apparently thereafter permanent, so that the individual cannot again drink in a controlled, socially acceptable manner. During this phase "dry periods" (i.e. going on the wagon) which represent remissions of the behavior pattern are common. Further, it should be understood that loss of control is not absolute for a brief period. However, the alcoholic who persists in drinking one or two drinks at a time will certainly soon end up drunk. The chronic phase includes the complications of alcoholism, such as alcoholic polyneuropathy, portal cirrhosis, delirium tremens, Korsakoff's psychosis, Wernicke's syndrome, and cerebral atrophy. Ambulatory individuals with certain of the above complications who are able to come to the clinic receive treatment.

The treatment of the alcoholic represents a coordinated effort of the different skills of the staff. The first interview, which is conducted by the clinical psychologist or the psychiatric social worker, is utilized to obtain pertinent historical information regarding the patient's drinking and social problems. An attempt is then made to resolve the immediate stresses so that the individual can devote his energies to working with his main problem.

Handling the immediate situation often involves requesting the help of social agencies to provide necessities for his family on an emergency basis. It may be necessary to contact his employer or public employment agencies to secure employment. Family counseling may prevent disruption

of the family, and strengthen family unity of purpose in dealing with the immediate stresses related to alcoholism. Referral of the patient to Alcoholics Anonymous has been of great value during this stage as well as in the later stages of treatment. The patient's physical condition may present an emergent problem which, if possible, is treated at our clinic, but, if necessary, hospitalization is arranged. We do not have a direct connection with any hospital, but have received splendid co-operation from hospitals in the community for this purpose.

If the patient wants treatment at the clinic, arrangement for a physical examination is made to evaluate presence of organic disease. Necessary laboratory work is then ordered. If any organic diseases are discovered every effort is made to correct these, utilizing whenever possible the services of the patient's private physician. It has been found that medical or surgical problems present may require a priority in treatment, and undoubtedly the general improvement of the patient's health increases the amount of energy he can use to work with his alcoholic problem.

If it is discovered that the patient is psychotic, is suffering from organic brain disease, or requires in-patient care for other reasons, he is referred to other available facilities. While there are few agencies that deal with the problem of alcoholism specifically, there are many resources that can be mobilized to help answer the individual's needs.

The emergency situation having been handled, treatment continues mainly through the psychotherapeutic relationship of one therapist with the patient. In addition, through staff conferences, or as special needs may arise, a co-ordinated effort of all the skills of the clinic is maintained.

Where supportive medical care is needed certain drugs have been used. These include Mephenesin which is frequently useful for the relief of tremors and tension states associated with alcoholism; Benadryl has been of value in certain cases because of its soporific action, and is used in preference to barbiturates or other sedatives to which the alcoholic is prone to become "addicted." In this connection it should be mentioned that considerable caution is advisable in prescribing habituating or addicting drugs to an alcoholic. Care should also be taken not to prescribe medication containing alcohol to a problem drinker. Vitamins and special diets are prescribed when

necessary, especially for the malnutrition one often sees in alcoholics. Adrenal cortical extracts have been used in some cases in conjunction with the other supportive treatment outlined. Antabuse is administered in selected cases only after the patient has been referred to a hospital where Antabuse therapy has been started.

Tentative Evaluation of Results

From April, 1950 through June, 1951, 444 patients were seen at the clinic. Because of the chronic nature of the disorder, and the many variables involved, and since no method of treatment has been developed which enables the alcoholic to drink in a controlled manner, it is advisable to think in terms of a remission and a re-adjustment rather than a cure.

In evaluating treatment results we have used the criteria suggested by Jacobsen and Martenson-Larsen,¹ as follows:

1. *Socially recovered*—designates a patient who can competently perform his work and live in harmony with his family. He may have relapses, but they are few, do not last more than twenty-four hours and do not influence his work or his family life.
2. *Much better*—designates a patient who can perform his work with integrity and who has had a few relapses that have not disturbed his social status.
3. *Somewhat better*—designates a patient that is somewhat improved but is subject to attacks which influence his work and/or his family life.
4. *Unchanged*—designates a patient in whom no real improvement has been noted.

To the above we have added a group labelled *Unknown* (5), to indicate that follow-up has not been possible. These we are listing as failures, although we realize that some of this group may actually have received some benefit from treatment. The results to date are shown in the accompanying table:

Socially recovered	Much better	Somewhat better	Unchanged	Unknown	Total
(1)	(2)	(3)	(4)	(5)	
128	93	31	12	180	444
29%	21%	7%	3%	40%	100%

Thus 50 per cent have shown substantial improvement, and another 7 per cent slight improvement, while 43 per cent are presumed to be unchanged.

(Continued on Page 729)

Doctors' Fees and the Wage Earner's Dollar

By Norman E. Clarke, M.D.

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THOSE WHO speak or work for socialization of the medical profession claim that doctors' fees have increased beyond the paying ability of the average American wage earner. Our total medical costs, like taxes and other living expenses, necessarily have increased with the passing years and our cheapened dollar, while the increased use of hospitals and modern diagnostic facilities, if there were no other reasons, would make higher sickness costs inevitable. However, the people who advocate socialized medicine mention softly, if at all, these new and now major parts in the cost of treating illness. They quote the obvious increase in total medical costs as supporting their assertion that high fees charged by physicians is the major cause of it all.

It is painfully obvious to anyone who has to work for a living that today's dollar has to cover numerous expenses that did not exist even several years ago. Our government takes prior lien on the employee's pay check and abstracts many dollars for his old age pension, social security and other deferred benefits. This involuntary contribution for a possible future security is part of the living cost, though of no personal current value. When the wage earner has made the payments on his automobile, refrigerator, television or radio set, and numerous other modern conveniences, he does feel cramped financially. With his pocketbook deflated by high taxes, alluring advertising and easy credits, his feeling of financial insecurity conditions a sympathetic attitude to the false dogma of something for nothing. The cost of unwanted, unexpected and unplanned-for illness makes the doctor and his fee an easy target to blame for financial embarrassment, and it becomes just an easy step for many people to believe the self-serving claim that doctors' fees are excessive.

This argument has gone on for years, so it is time to look at the record. The question is: are present-day doctor fees beyond the paying ability of the people with average incomes or, putting it in a provable manner, have doctors' fees increased out of proportion to the average wage earner's

income? To answer this question we must first go back to a period when taxes were reasonable and the temptation to mortgage income for luxuries did not exist.

For determining the real cost of a physician's fee, its variation in cost at different times, or the ability of wage earners to pay for such a service, we must compare the fee with the number of hourly wages a man needs earn to pay for it. For example, how many industrial hours' pay were required in 1893 to pay for a specific doctor's fee as compared to the present-day hourly wages required to pay for the same service. With this yardstick applied to a sufficient variety of medical fees over this period of almost sixty years, we can learn whether doctors' fees have become excessive and beyond the paying ability of working people. We must assume everyone's willingness to consider reasonable ability to pay as being confined to the purchase of life necessities without considering the obligations of unnecessary luxury purchases or excessive taxes.

The fact that industrial workers income has increased progressively during the past sixty years is presented in the book by Paul H. Douglas entitled "Real Wages in the United States—1890-1926." For the years after 1926 we find continuing information in the "Statistical Abstract of the United States," published by the United States Department of Commerce in 1949, and the later "Industry Report" of the United States Department of Labor. These compiled records show that the average hourly wage rate for all industry in 1893 was 21.6 cents; by 1910 it had risen to 28.8 cents, and in August, 1950, the average hourly earnings in manufacturing were \$1.46 an hour and, of course, are still higher today.

During this same period of years the standard work week in all industry gradually declined. In 1893 the industrial wage earner worked 58.2 hours a week; by 1926 this had fallen to 49.8 hours, and in 1946 it was 40.1 hours. With this reduction in hours worked per week, the average weekly earnings of all employed in industry rose from \$10.93 in 1893 to \$32.39 in 1926, and in August of 1950 they had risen to \$60.32. So over a period of fifty-seven years the average wage earner employed in industry increased his earnings from \$10.93 for a work week of 58.2 hours to \$60.32 in 1950 when working 40 hours per week. The industrial workers weekly income, therefore, in-

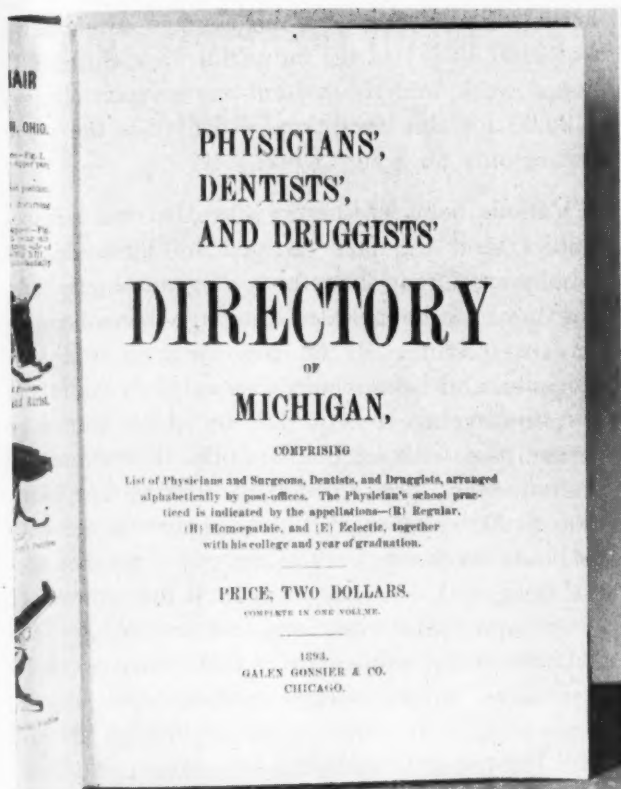


Fig. 1

MEDICAL FEE BILL.	
Ordinary office prescription	25 to 50
Investigation in office requiring considerable time	2 to 10
Visits in city in regular attendance (day)	1 to 3
Visits in city in regular attendance, after 10 p. m.	2 to 5
Visits in country, extra per mile	1
Opinion involving a question of law, or attendance at court as an expert (per day)	10 to 50
Examination for life insurance	3
Vaccination	0.50 to 1
Urinanalysis by chemical tests	2 to 10
Microscopical examination of urine	2 to 10
Consultation visits	5 to 50
Visit in case of poisoning	3 to 5
Administering anesthetic	2 to 5
OBSTETRICS.	
Ordinary cases of labor	10 to 30
Abortions same as labor	10 to 40
Delivery by forceps, additional	5 to 15
Delivery of placenta	5 to 10
Embryotomy	10 to 40
Consultation	5 to 15
Primary perineorrhaphy	10 to 50
GYNECOLOGICAL.	
Late perineorrhaphy	10 to 100
Ovariectomy	25 to 200
Laparoectomy	25 to 200
Hysterectomy	150 to 500
Hysterorrhaphy	100 to 250
Trachelorrhaphy	25 to 100

Fig. 2

creased 550 per cent in fifty-seven years although working eighteen hours less.

There are no inclusive records of physicians earned income or hours worked for the years 1893 to 1950, but these are not necessary, and income alone could be misleading, for a doctor's cash earnings will vary with the hours worked and the amount of his fees collected. Doctors' incomes have increased, but there has been no reduction in the number of hours worked each week by practicing physicians. It is a certainty that the average practicing physician of today devotes as many hours to his practice as did the physician of sixty years ago, and it seems equally certain that the average present-day physician's income does not exceed by 550 per cent that earned by doctors sixty years ago.

The Michigan State Medical Society published in 1893 a book entitled "Physicians, Dentists and Druggists Directory of Michigan," which lists the medical fees charged by physicians of that day, giving the minimum and maximum fee for specific medical and surgical services (Figs. 1 and 2). As the advocates of socialized medicine have chosen to base much of their propaganda on doctors' fees, the argument can be met by comparing the present-day fees of Michigan physicians, which

are representative of the same in other states, with those charged sixty years ago and, similarly, comparing with the hourly earned wages of the two periods.

A few representative medical services with corresponding hourly wage incomes will give the facts. The preliminary to medical care is a general physical examination which usually is performed in the physician's office. The Michigan doctor of 1893 charged an average fee of six dollars for this service so the average industrial workman earning 21.6 cents an hour was required to work 27.8 hours to pay for this service. Today the general medical practitioner in an industrial city like Detroit charges ten dollars for a general physical examination, and the medical specialist charges fifteen dollars. The present industrial wage earner, paid \$1.46 or more an hour, can purchase his general medical examination from a general practitioner for 6.2 hours' work. He can have a physical examination by a specialist for 9.4 hours' work. Such examinations occasionally are followed by laboratory or x-ray studies which have been mentioned as increasing the cost and which might support the alleged inability to pay. It should be emphasized that these additional studies are not a part of most physical examinations but,

where necessary, today's wage earner still has 21.6 hours wages to spend before the actual cost of his modern over-all examination equals what his fellow paid in 1893. If he spent the same time, 27.8 hours, that the earlier worker did, he would pay \$40.58 for his general physical examination, and this is more than most people have to pay for this service.

When consultation was required in the nineties, the consultant's fee averaged \$26.50 and was paid by the industrial wage earner with the wages of 122.6 hours' work. Today, in cities like Detroit, the average specialist consultation fee is \$25, so the wage earner worked but 17 hours to pay for this medical service. This uncommon medical expense, therefore, can be purchased for less than one-seventh of that paid by the industrial worker of 1893, and with this great saving the present medical consultant gives the benefit of sixty years' advance in medical knowledge.

A necessary medical service is child delivery, and there were few obstetrical specialists in 1893, when the average fee was \$20, which did not include before-and-after delivery service. The fee of present obstetrical specialists varies, with some being high, but for people of average income, exclusive of before-and-after delivery care, an average fee is not more than \$100. When an industrial wage earner's wife had a baby in 1893, he worked 92.5 hours to pay the doctor's fee, but today his wife can have the services of a specialist and the fee be paid with only 69 hours' work. The modern general practitioner is a competent obstetrician, and his child delivery fee averages \$50, which permits this important service to be purchased for only 35 hours' work. Much has been said about catastrophic illness, meaning, usually, the expense of major surgery, as the cost of prolonged chronic illnesses like tuberculosis and mental disease is now assumed largely by government. One of the commonest surgical operations is hysterectomy, or removal of the female womb. The average fee for this operation in 1893 was \$325, which was paid by the wage earner with 1,504 hours' work. Today, qualified surgeons charge \$200 for this operation, which the wage earner can pay for with only 137 hours' work. Again he gets the superior skill of the modern surgical specialist and at a saving of 1,367 hours' work, or he pays less than 10 per cent of its former cost. Another common operation is for correction of uncomplicated rupture or

hernia. Sixty years ago the average surgical fee was \$100, or it cost the industrial wage earner 485 hours' work, and the present-day surgeon charges \$125.00 for this operation, which costs the wage earner only 86 hours' work.

Various fields of surgery have become subspecialties, and the fees charged by these doctors usually are larger than those of general surgeons, but they must be included in today's over-all medical cost picture. Rectal surgery is such a subspecialty, and hemorrhoid removal sixty years ago cost the average fee of \$21.50, which the wage earner paid with 99 hours' work. The same operation today, performed by a surgical specialist, costs \$100, which is paid by the wage earner with 69 hours' work. Surgery of the eye is another special field, and when they operated for removal of eye cataract sixty years ago, the average fee was \$112.50 or the equivalent of 520 hours' work by the wage earner. The modern eye surgeon charges \$200 for this operation, which is paid with 138 hours' work by the wage earner. The present-day wage earner purchases this operation for about one-fourth of what it cost sixty years ago. The fitting of glasses is required sooner or later by most people, and in 1893 the doctor's fee averaged \$6 or 27.7 hours' work of a wage earner. The fee for this same service today averages \$10 and can be paid with the wages of seven hours' work.

The specialty of orthopedics is one of the smaller specialty groups and their fees, generally, have increased more than in other surgical fields. In 1893 the average fee for setting a fracture of the humerus or a broken bone in the upper arm was \$17.50, which was paid with 80 hours' work by the wage earner. This same service today, when performed by a qualified orthopedic specialist, costs \$100 or 69 hours' work by the wage earner. If the leg was amputated at the thigh in 1893, the average surgical fee was \$87.50, which cost the wage earner 405 hours' work, but today the fee for this operation is \$200, which costs the wage earner only 138 hours' work.

One could multiply these examples, and all would show the same decline in the real cost of physicians' fees. This true yardstick of cost reveals clearly that physicians' and surgeons' fees today are not excessive or beyond the paying ability of working people and remain as the only essential

(Continued on Page 731)

Poliomyelitis and Injections

By Mario S. Cioffari, M.D.

Detroit, Michigan

THIS YEAR something new has been added: the question of whether there is any connection between all types of hypodermic injections and the incidence and severity of poliomyelitis. The importance is obvious; we have been trying for years to convince people of the necessity of immunization, and now considerable doubt has already developed in the minds of parents, whether to have the injections during the summer, or whether to have them at all, which is very regrettable.

It is with this thought in mind that the present study was undertaken. The shadow has been cast on all inoculations, therapeutic or otherwise. Writers presenting more recent data have been trying to exonerate allergic or therapeutic injections, but still blaming the others. Even here the general consensus is that injections *per se* do not bring on an attack of poliomyelitis but that the infection will tend to localize in the injected limb and be more severe. Some have theorized that the child may have a dormant infection which is aroused by the serum.

It is our purpose to prove these points: that an injection will not induce poliomyelitis and that it is rash to postpone necessary protection and treatment on the remote possibility of making an acquired infection worse.

Guy Bousfield¹ gave 293 children two injections each, one month apart during a severe epidemic of polio, with no resulting paralyses. Two other English investigators, A. Bradford Hill and J. Knowelden,⁴ are not convinced of any relation. They state that with the available data the relative risk of poliomyelitis after inoculation, either at different ages or with different antigens, cannot be assessed.

B. P. McCloskey⁵ has a series of thirty-one cases of paralysis within three months in a group of 340, with emphasis on pertussis vaccine as the main culprit. He states, "The parents of children were naturally inclined to blame the inoculations for the development of the disease."

In another series,⁶ fourteen cases out of 495 under ten had been immunized within one month. Even admitting abnormal types of paralyses, the

percentage here is also too low to be completely free of doubt about chance localization. This investigator deduced, "There appears to be no relationship between the substance inoculated and the paralysis." He also gives a word of warning: "It is admitted that any measure affecting the immunization campaign must be given most careful thought lest more harm than good ensue," and, "In any case when the number of inoculations given is considered, these complications are obviously rare."

In preparing this report, we have closely examined the records in our private practice. These are all children of middle class families, residing in Wayne and Oakland Counties, Michigan, from the age of six weeks to fifteen years. We were not primarily concerned with the number of children involved, but rather with the location, type, number of inoculations, and the type of serum used.

The following serums are involved in this series: alum precipitated pertussis, diphtheria-tetanus, and diphtheria-pertussis-tetanus, with fluid diphtheria or tetanus for those over ten years of age, catarrhal vaccine, influenzal vaccine, Schick and Dick tests, smallpox vaccine, precipitated scarlet fever serum, and gonadotropic hormone. By far the largest number were immunizing antigens; penicillin, adrenalin, or allergy injections were not included.

The survey covers four years, and this year only was the advisability of summer injections discussed with the parents. There were none who, having come to the office, considered the risk so great as to postpone the injections. For our purpose, the period was limited to the time from May 1 to November 1, 1948-1950 and May 1 to September 1, 1951, as being representative.

Within these boundaries there were given 3,200 injections to 1,601 children; of these, 1,664 were in 785 boys and 1,536 in 816 girls; 401 children under six months received 949 injections, and 1,260 children over six months received 2,251 injections. The breakdown is shown in Tables I and II.

The smallest number of injections per child was one, and the largest nine, each of which would have been a separate contamination if any virus were introduced at the time.

This representative series of children produced not one case of site-correlated polio within three months of injection. The longest interval that is

POLIOMYELITIS AND INJECTIONS—CIOFFARI

TABLE I. INJECTIONS IN BOYS

Age	1948	1949	1950	1951	Cases of Polio
1-5 mo.	75	73	142	165	0
6 mo.-1 yr.	151	127	176	145	0
2-5 yrs.	48	80	171	114	0
6-10 yrs.	40	38	54	41	1
11-15 yrs.	1	7	4	10	0
Totals	315	325	547	475	1

now claimed to have any bearing is thirty days. There was only one child who developed polio within four weeks. He was nine years old, had had injections in both triceps, and developed slight weakness of the soft palate, left gastrocnemius and anterior tibial muscles within two weeks of inoculation.

During this period of observation 1948-1951, we have had quite severe epidemics in this area, the incidence rate of children under fifteen years going up to .88 per 1,000 in 1949. Many of our children were undoubtedly exposed without contracting the disease.

The severity of the reaction from the inoculation is thought by some to have a bearing on the resulting paralysis. We have noticed in our series that the child will have a progressively increased reaction in relation to age, starting at about one year of age, irrespective of the brand of serum; children from five to ten years of age, for instance, will regularly have a severe local and sometimes a systemic reaction, so much so that we don't give triple vaccine from four years up and only fluid serum from ten years of age and up. The factor of local reaction is therefore too common to be taken into consideration.

L. S. Goerke,³ following his survey in the Los Angeles Health Department, is convinced that we are doing more harm than good by the summer ban. He states, "It appears inadvisable to permit the chance occurrence of poliomyelitis following injections to interfere with the continued mass elimination of diseases equally crippling and fatal." His observations do not show any marked difference between the recently immunized and the controls.

Somewhat in the same vein is an editorial² re-evaluating our present stand: "... Now we turn and say avoid them (injections) during the polio season. It will be a difficult task to make the public understand that the immunizations and injections do not predispose a child to polio. ... We must not lose what has been gained over the last twenty-five years because of the hysteria engen-

TABLE II. INJECTIONS IN GIRLS

Age	1948	1949	1950	1951	Cases of Polio
1-5 mo.	84	105	139	166	0
6 mo.-1 yr.	105	141	170	134	0
2-5 yrs.	69	80	86	112	0
6-10 yrs.	41	47	20	22	0
11-15 yrs.	2	3	2	8	0
Totals	301	376	417	442	0

dered by the recent polio campaign. . . . The final responsibility rests on the judgment of the physician in determining the relative importance of the risks."

Discussion

In this article we have shown that there is no relation between an injection and the inciting of poliomyelitis. The chance of reactivating whooping cough or diphtheria epidemics is real, but of acquiring paralytic polio at all, is slight. That an infection may be worse and may localize in the injected limb is still debatable.

In our series, by far the largest percentage of school children came for their inoculations in the warm months: toward the beginning or end of the school year, and through the summer. When an older child comes in for a booster injection, or what is more serious, if he comes in without any previous protection, in May or June, it does not seem reasonable to postpone antigens until November (30 per cent of polio cases occur October through December).⁶ There will be an additional lag of three to four months to produce immunity in virgin territory.

Are we to let that child be a potential hazard to himself and community for six months to a year longer? The problem must still be left to the discretion of the individual doctor. We do not stop athletics, national sports and strenuous children's games during the summer, though there is more evidence about the evil effect of exhaustion in polio.

The summer vacation is the logical time for immunizing older children; they are in better health, they are out of school, and are coming in for check-ups anyway. Many have not had boosters since infancy and are, therefore, very susceptible to communicable diseases.

The question of whether the paralysis will localize in the left arm or right leg seems almost academic, but it would be a more serious decision to make between bulbar type and an extremity.

We know very little about poliomyelitis; we are

continually stabbing in the dark or grabbing at straws as to how it may be spread. Once a child has acquired the disease, it is easy enough to blame anything that came before and find a relation to it.

The only thing that we are sure about polio is that it is a very unpredictable disease; that, like a tornado, it will affect one child in a family and none of the others, or it may affect all four or five siblings; one year the individual cases of an epidemic are very mild, and the next will bring severe paralyzes and a high mortality; in some areas the case incidence will be high, and just as unexpectedly the next visitation will give a very low incidence. We shall, therefore, need many more thousands of severe paralytics, immunized within the previous month, before we stop immunizations for six months out of the year. Even that would not change the relative risks. Statistically, the chances of getting severe paralytic polio are infinitesimal as compared to the millions of injections of all types given each year.

We have nothing tangible to offer parents on the prevention of poliomyelitis, and not much after paralysis has occurred, but we do have something very tangible for prophylaxis of whooping cough and diphtheria. Mortality has been reduced from 7.4 per 100,000 in 1900 for the former, to 0.4 per 100,000 in 1950, and from 29.1 per 100,000 in 1900 for the latter to 0.0 per 100,000 in 1950. This was not done by spasmodic campaigns, but by very persistent efforts by all concerned. We feel, therefore, that immunization against the communicable diseases should be carried out the year around. You cannot turn them on and off like a faucet; you cannot make the public immunization conscious one minute, and distrusting the next.

Summary and Conclusions

1. In the four years 1948-1951 we have given 3,200 injections in our private practice during the months in question—1,664 in boys and 1,536 in girls from the age of six weeks to fifteen years.
2. The serums and vaccines included were pertussis, diphtheria, and tetanus—single and in combination, fluid and alum-precipitated—smallpox, scarlet fever, influenza, and catarrhal vaccine, Schick and Dick tests.
3. In this series there was only one very mild paralytic polio case within three months of injection, not related to the site of inoculation.
4. We feel that there is no relation between the

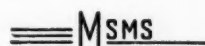
incidence rate of polio and injections of any kind. If there is any relation to severity, the proof is still forthcoming; the weight of evidence thus far presented does not warrant the postponement of protection and treatment by injection for a period of six to eight months out of the year.

5. It would be advisable, for the present at least, to finish the first series of immunizations by six to seven months of age, and to give the occasional booster when necessary.

References

1. Bousfield, Guy: Paralyzes following immunizing injections: measures calculated to diminish risk. *Lancet*, 1:1028-1032 (May 12) 1951.
2. Editor's Column: Polio problems for the pediatrician. *J. Pediat.*, 39:2,263 (Aug.) 1951.
3. Goerke, L. S.: Poliomyelitis, precipitation by injections. *California Med.*, 74:383-384 (May) 1951.
4. Hill, A. B., and Knowelden, J.: Inoculation and poliomyelitis: statistical investigation in England and Wales in 1949. *Brit. M.J.*, 2:1-6 (July 1) 1950.
5. McCloskey, B. P.: The relation of prophylactic inoculations to the onset of poliomyelitis. *Lancet*, 258:659 (April) 1950.
6. Martin, J. K.: Local paralysis in children after injections. *Arch. Dis. Child.*, 25:1 (March) 1950.

AD—Two (2) Mono Tables



THE TREATMENT OF ALCOHOLISM IN AN OUT-PATIENT CLINIC

(Continued from Page 723)

Because of the brief period of follow-up of many of the patients, it should be emphasized that the results are only tentative. They show that, given constructive aid, alcoholics will react favorably. How effective the help is can be evaluated fully only after the patient has been observed for a sufficiently long period of time.

Summary

The clinic represents the first attempt in this State to treat alcoholism at a community level. It is felt that the results obtained have justified the efforts and money expended. An extension of this program through similar agencies on a state-wide basis should be contemplated.

References

1. Jacobsen, E., and Martenson-Larsen, O.: Treatment of alcoholism with tetraethylthiuram disulfide (Antabus). *J.A.M.A.*, 139:918 (April 2) 1949.
2. Jellinek, E.M.: Phases in the Drinking History of Alcoholics (Memoirs) the Section of Studies on Alcohol, Yale University, (No. 5) New Haven; Hillhouse Press; 1946. Also in *Quar. J. Studies on Alcohol*, 6:1-88 (June) 1946.

Detroit Physiological Society and the Society of the Sigma Xi

JOINT MEETING OF APRIL 24, 1952

Radioisotopes, Their Properties and Applications to Chemistry

R. B. HAHN

Department of Chemistry, Wayne University, Detroit

Radioactive substances emit three types of radiation: positively charged alpha particles, negatively charged beta particles and gamma rays. These radiations can be measured with an electroscope or Geiger-Mueller counter. Thus, very minute amounts of radioactive isotopes can be detected.

Since radioactive isotopes have the same chemical properties as the inactive isotope, they can be used as "tracers" in studying various chemical reactions. By the use of C^{14} , the mechanisms of various organic reactions have been determined. The efficiency of various methods of chemical separations can be studied by using mixtures of radioactive isotopes. By activating certain elements with neutrons, minute quantities, undetectable by any other method, can be measured. Radioactive isotopes have become an important tool to the chemist.

Some Applications of Radioisotope to Engineering Problems

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College of Engineering, Wayne University, Detroit

The properties and characteristics of radio isotopes which make them valuable tools in industry may be listed as follows:

The radiation from isotopes penetrates containers and opaque walls of any material; the radiation is absorbed in logarithmic proportion to the thickness and density of any material it passes through; radiation destroys bacteria; radiation ionizes gases and dust particles; radiation is scattered by liquids and solids; minute quantities of radio isotopes are detectable; chemically identical atoms may be differentiated because of radiation; fast neutrons are slowed down by moderators such

as paraffine or water; and slow neutrons striking some atoms make them radioactive.

Each of these properties is useful in the application of Radioisotopes to the solution of industrial and engineering problems.

Radioactive Isotopes in Biochemical and Metabolic Studies

RALPH M. JOHNSON

Detroit Institute of Cancer Research

Direct chemical analyses of animal tissues for elements or metabolites have failed to provide many of the details of metabolism of the substances. "Tagging" of the element or metabolite, however, has facilitated following its course of utilization. Radioactive isotopes have found by far the widest use of any of the labelling substances that are introduced into the body for the purpose of making biochemical and metabolic studies.

One of the greatest fundamental contributions made by this tool in biochemical research has been in the study of transfer of materials across membranes within the organism. Factors affecting absorption of nutrients from the intestine may be cited as an example of this. Another field investigated with the aid of radioactivity has concerned the production of secretory and excretory products by the various specialized tissues and organs of the body. Factors influencing, or concerned in the utilization of, vital metabolites have been elucidated using radioactive isotopes, and in general, it is now known that there is a constant renewal of most of the body constituents. In the mature animal, for example, most of the materials in the body remain at a fairly constant amount, the continuous degradative processes corresponding closely to the formation of those substances.

Examples were given of the use of P^{32} in biochemical studies. Its employment has provided evidence that a phosphoprotein exists which is important in the intermediary metabolism of phosphate. In another instance it was shown that there is an increased phosphorylative activity in acid

soluble organic phosphoprotein, and nucleic acid fractions within cells during the period of cell growth and immediately prior to cell division. Phospholipid phosphorylation appears to be more closely associated with cell division.

Diagnostic and Therapeutic Use of Radioisotopes in Medicine

R. W. SMITH, JR., M.D.

Henry Ford Hospital, Detroit

Attention was called first to the historical significance of radium. From extensive experience with this natural radioactive element has come much of our understanding of the biological effects of radioactivity in man. The value of radioactive phosphorus (P^{32}) in treating polycythemia vera and leukemia was discussed. Its use diagnostically in suspected brain tumors, in differentiating breast tumors, and in hyperparathyroidism was then reviewed. Considerations were given to the use of P^{32} in determining blood and plasma volumes, circulation times and peripheral diffusion rates. The role of radioactive iodine (I^{131}) in the diagnosis and treatment of thyroid disorders, including carcinoma, was then reviewed. Both the assets and debits were acknowledged. Attention was given to its use in locating intracranial tumors when the isotope was incorporated into the fluorescein and albumin molecules. I^{131} -tagged albumin has been used to determine circulation times and plasma volumes while the inorganic I^{131} has found a limited place in treating certain refractory heart problems. Radioactive sodium (Na^{24}) has been proven of value in measuring peripheral diffusion rates, circulation times and extracellular fluid volume. The recent uses of radioactive gold (Au^{198}) in treating effusions arising secondarily to malignancies were then reviewed, as were its applications to the direct treatment of uterine cervix and prostatic carcinomas. The increasingly important role of radioactive cobalt (Co^{60}) in medicine as an inexpensive substitute for radium was noted, brief attention being given to the reasons why Co^{60} is threatening to replace radium as a source of therapeutic radiation. Finally, brief mention was made of the limited experiences reported with gallium⁷², strontium⁸⁹, bromine⁸² and arsenic.⁷¹ It was stated, summarily, that the radioactive isotopes were of growing importance to medicine but that in no sense could they be considered as revolutionary.

JUNE, 1952

DOCTORS' FEES AND THE WAGE EARNER'S DOLLAR

(Continued from Page 726)

living cost that has been greatly reduced over the years.

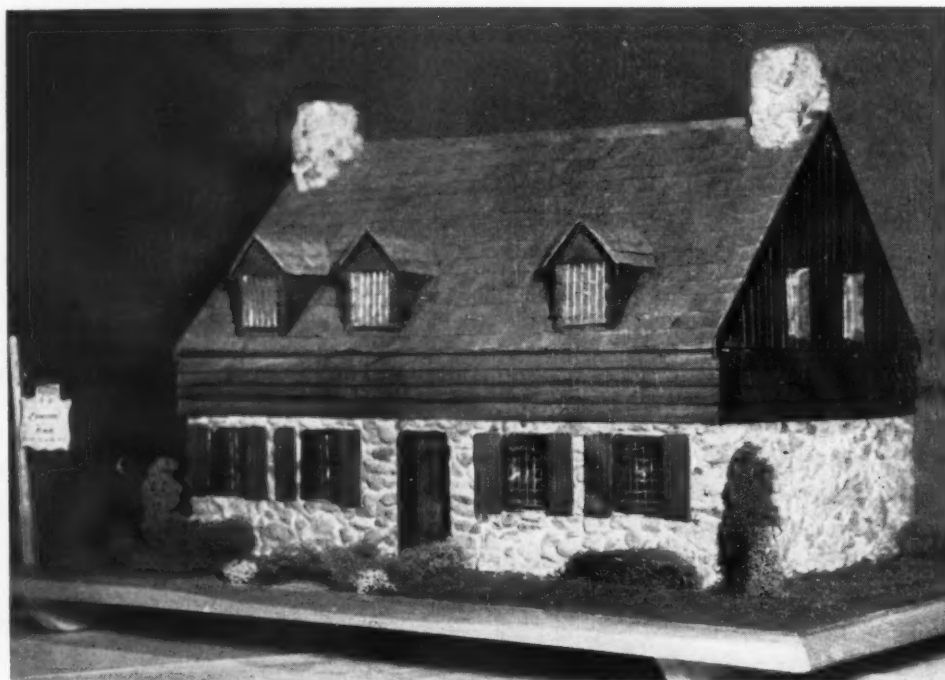
This can be further demonstrated by taking an average wage earner and his family in 1893 and assuming that in a year's time the father required a general physical examination and a consultation of physicians, his wife was delivered of a child by the family physician, a son was operated for rupture and another child had an eye examination for the fitting of glasses. Such combined medical expense in one year is unusual, and in 1893 it cost the wage earner \$158.50 in average doctors' fees, which he paid with 734 hourly earnings or about 12.5 weeks' work. If this same series of medical and surgical experiences occurred in the family of a wage earner today, the average fees would total \$220, which could be paid with 150 hourly earnings. The wage earner in 1950 could purchase with three and three-quarters weeks' work the medical services that cost his fellow 12.5 weeks' work in 1893.

There can be no dispute about the rise in living costs over the past sixty years but the present wage earner can purchase his doctor's services, in general, for less than one-third of what it cost sixty years ago. The past generation of Americans did not think of socializing medicine nor is there reason to believe that they considered their doctors' fees high. The new methods for diagnosis have increased the over-all cost of medical care, but the greatly increased purchasing power of the present wage earner's dollar allows him to pay these additional diagnostic fees and still get his medical care for less than such service cost sixty years ago, because the medical profession has not advanced the size of its fees in proportion to their patients' earned ability to pay. The prudent worker must accept the responsibility of paying for necessities before purchasing luxuries.

OPHTHALMIC MINIATURE

Having been informed the night (of) the death of a poor man in the hospital, that he had a cataract in one of his eyes, I removed the eye a short time after death, and carried it home. On opening it, I observed that the cataract occupied the place of the crystalline, and appeared to be that badly.—A. MARTRE, Jan. 1707.

President's Page



MODEL OF BEAUMONT MEMORIAL RESTORATION

The Beaumont Memorial Fund has reached one third of its goal. One hundred per cent contribution has been received from the membership of the Genesee County Medical Society. The Woman's Auxiliary of the Wayne County Medical Society has sent in a substantial sum. This is a good beginning for a project which has special interest to all doctors of medicine in Michigan, for it was in Michigan that Doctor William Beaumont made his pioneering observations.

Join your fellow doctors of medicine in recreating this historic medical shrine.

Otto O. Beck

President, Michigan State
Medical Society

Editorial

MICHIGAN STATE MEDICAL SOCIETY ANNUAL SESSION
SHERATON-CADILLAC HOTEL—DETROIT
September 24-25-26, 1952

WE ARE PROUD TO REPORT

FOR MANY YEARS the social planners who are always suggesting some change in our economic or sociologic outlook have been giving their attention to the practice of medicine. This situation started with Bismarck in our near modern times. He was ambitious for the German "Kultur," and by offering hard to get health services to the bulk of the serfs and working people built up a following, an army, and ultimately the German Empire. His ambition was POWER.

We have had social planners in the past couple of decades, with the same ambition, and the same technique. They wish to control large groups of people and their economy and are willing to offer scarce and much needed benefits for the sake of gaining the plaudits, the gratitude, and the following of these beneficiaries. Again they selected the medical profession, probably because that profession has universally the respect and confidence of friends and patients. The medical profession was composed of highly individualized persons, used to working alone, to being their own best advisers. They consulted and fraternized in matters scientific, but shunned all appearance of being economic minded. They were, as a profession, ideal sitting ducks for the attention of the social planners.

Suggestions were made that the costs of medical care were high—too high. It was suggested slyly that government might do a better job of distribution of our services. It was claimed a considerable number of our population, 40 per cent, were not getting what they called adequate medical service. Surveys showed that statement to be false, but constant repetition made it bear the weight of truth. It was repeatedly made for many years, and even just recently. Such reiteration has presumably gained the semblance of truth. Communists teach if a statement is made often enough people will believe it. Social planners seem to be of the same brand of thinking.

Plans were made for various forms of government control, and the medical profession promptly opposed. Murray-Wagner-Dingell bill after bill was

introduced, and we always opposed, until we ourselves hesitated to be always "opposed." We were asked by our friends and our opponents also, "Why is the medical profession always opposed?" "Why do they never offer some plan of their own?" "Why always *against* and never *for anything*?"

Michigan Medicine accepted the challenge, and proposed a plan to distribute medical care in catastrophic cases so that anyone who wished could be assured of medical services and protection from financial calamity when sickness comes. Michigan medicine is proud of its efforts, and presents in this issue another report to our constituents. The profession has partially stymied the progress of socialized medicine as a grand social upheaval. We doubt if the plan can be put across in one fell swoop as was contemplated by the various Wagner, Murray, Dingell bills, and their successors. The profession is now too alert for frontal attack.

FORMULA FOR FREEDOM

OUR FOREFATHERS came to America to escape oppression. They came to find freedom. They built a nation of individualists who were capable and willing to make their own way, to provide for their needs, to protect and cherish their families. They established the basic foundation of Americanism, the ability and intention to earn their own living. In time they banded together to establish a government with limited powers granted by the Constitution, all other powers to be retained. Such a society and such a philosophy was entirely new in the world, but the world was ready and it came into being in America.

Time and more complicated conditions have prompted the assignment of more duties to government. As long as that was voluntary and knowingly done all was well. But for some years there has been a growing assumption of authority and power by government. Government has become our competitor, both by law and by executive regulation and has gone into business. Small or big, business as administered by government is

inefficient. Early the Post Office system was declared a government monopoly, and has it ever run without a deficit? Politics does not produce good businessmen.

Social planners have intruded themselves into government, and are given the guiding hand. A very few determined workers can do great things. Witness the Tennessee Valley Authority. It was established for flood control, but entered the business of power, in competition with the driving out private enterprise. That is just one federal corporation. There are 88 listed, costing us about thirteen and a half billions of dollars annually, just to do business in competition with us. They pay no taxes. If privately owned and operated they would not only *not* have a deficit each year, they would materially aid in carrying our tax burden.

In addition there are over thirty different programs in the government which furnish medical and hospital care to groups of our citizens. These are in competition with each one of us, and with our private hospitals. They pay no income or other taxes, but we who have to compete do pay taxes.

One of the tenets of our Michigan Formula For Freedom is that many persons co-operate—unite their forces and resources and abilities to the end that we may preserve and enjoy our freedom to the best advantage.

About three years ago a group of far seeing citizens of Los Angeles decided to stop opposing the development of big government, and to do something about government. They have proposed the twenty-third amendment reading as follows:

"The Government of the United States shall not engage in any business, professional, commercial or industrial enterprise in competition with its citizens, except as specified in the Constitution."

Such an amendment would stop the threat of socializing not only business and industry, but medicine.

GOVERNMENT INEFFICIENCY OR INEPTITUDE

SOME YEARS AGO a medical friend was building a picket fence to hide an area containing a garbage can, and to keep out a neighbor's dog. The neighbor without investigation got out an injunction, prohibiting the building of the fence, and dragged the friend into court. The case was settled easily after the attorneys had their

say, and the fence being proven harmless was allowed. An unnecessary expense, an unnecessary delay, and no redress. The friend was a victim.

Some years ago there was a concerted effort to put the medical man and his profession in a bad light before the public. The American Medical Association was brought into court under the Sherman Antitrust law, and much unfavorable publicity given to the so-called "Medical Trust." Thurman Arnold, the assistant Attorney General of the United States, made trips all over the country telling audiences who would listen what horrible things were being "proven" against the medical trust in the *grand jury*. Finally the case came to trial; the profession had been put to tremendous expense, and had suffered a loss of prestige it has taken years to regain. The American Medical Association was a victim.

Four or five years ago federal executive officers began seeking other ways of embarrassing the profession. They visited the offices of over twenty State Medical Societies and Service Plans including Michigan, ghost hunting, looking for anything which could be used against the profession which was opposing the program of the social planners. In October, 1948, suit was brought against the Oregon State Medical Society, the Oregon Physicians Service, eight County medical societies and eight individual doctors, charging conspiracy in restraint of trade. The trial judge directed a verdict for the society, but the case was appealed directly to the Supreme Court, instead of an intermediary. On April 28, 1952 the Supreme Court of the United States in a seven to one (one not voting) decision dismissed the appeal. A tremendous and unnecessary expense to the Oregon State Medical Society, a great loss of prestige until the final verdict. The Oregon State Medical Society was a victim.

At the beginning of what the Government calls the "Korean Incident" an effort was made to stabilize prices and costs. A program was announced to control and to restrain inflation. Officials were appointed for that purpose whose duty it was to regulate all increases in prices. That group has attempted to function according to its best information and to the limit of its powers.

The Government also set up a board to study and control wages. This latter board when the steel wage dispute came up, without consideration of the effect of its contemplated action, offered a wage raise in excess of what the labor group had

asked, and so far out of line that only inflation could result if adopted. That board's report was tantamount to a complete acceptance. One government group was attempting to restrain and control inflation and the other was boosting inflation by its action in considering the same basic controversy.

The government also double-crossed the industry concerned. The steel companies had been promised a raise sufficient to carry the increased costs of the inflated wages which would be necessary; but this was denied by the President, and industry had no alternative but refuse the strike settlement terms. The result—incalculable loss to our economy, a set-back to our defense program, and wage loss to hundreds of thousands of workers. All this because two government agencies did not try to understand each other's problem, and reach a common decision in the light of the common good.

Other departments of Government are just as apt to do the unaccountable and the unjustifiable thing. Witness the following editorial quoted from *Steel*, December 17, 1951:

REMEDY FOR INJUSTICE

Three years ago the Justice Department obtained indictments against 14 paint manufacturing companies and 21 officials of these companies for alleged violation of the Sherman anti-trust laws. The companies and individuals were charged with conspiracy in fixing paint prices, discounts and allowances.

The story of these cases should interest thousands of metalworking companies because it demonstrates clearly what might have been the rainbow finish of numerous metalworking industry cases had the defendants been willing or financially able to fight for principle.

Here is the story: All defendant paint companies and individuals were confident they were innocent, yet they realized clearly they had two alternatives. Either they could plead "nolo contendere" and get off with a fine of a few thousand dollars or they could fight their cases in court which would cost many tens of thousands of dollars and consume months or years of time.

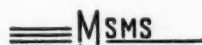
Twelve companies pleaded "nolo contendere" and were fined \$5,000 each. Twenty individuals pleaded similarly and were assessed fines ranging from \$1,000 to \$3,500 each. The twenty-first individual fought the indictment and the government dismissed its charges against him. The thirteenth and fourteenth companies—E. I. du Pont de Nemours & Co. and Glidden Co.—carried their fight to a federal district court where a jury acquitted them. It cost the Glidden Co. about \$100,000 to prove its innocence, and it may be assumed that Du Pont spent as much or more. The companies and persons pleading "nolo contendere," although later

found to be innocent, paid out more than \$110,000 in what amounted to a virtual "shakedown" by their government.

This type of extortion cannot be justified on any score. The reason for it is that the anti-business atmosphere which has pervaded Washington in recent years makes it too easy for the Justice Department to obtain indictments on insufficient or faulty evidence.

One remedy would be to require the government to compensate the defendant for his costs if he is acquitted. This would force government lawyers to prepare their cases more carefully and it would encourage honest defendants—especially small ones—to fight to protect their good names.

E. L. SHAMER, Editor-in-Chief,
Steel, December 17, 1952



RETIREMENT DREAMS TURN INTO NIGHTMARES

Despite the sudden mushrooming of pension plans in recent years, "retirement" is becoming a word of dread to many elderly people. The reason is that inflation has drained it of much of its pleasant connotation.

As the Government's Bureau of Labor Statistics price index has climbed nearly 90 per cent above the 1935-39 average, the word has become more and more synonymous with struggle, hardship and, in some cases, poverty.

A survey of various groups of retired persons shows that a substantial number are being forced to go back to work, often at jobs far less satisfactory than those they left.

Others, less fortunate, have found that even unsuitable jobs are denied persons of retirement age.

The plight of many of Detroit's retired Board of Education employees is typical of persons who are attempting to live on pensions established before the full impact of inflation was felt.

Miss Jennie Fleming, chairman of the pension committee of the Detroit Teachers Association, points out that teachers who retired before 1945 are limited to maximum benefits of \$110 a month, set up in the middle of the depression-stricken 1930s.

The Board of Education has attempted to boost the pensions of this group, but has not been able to get permissive legislation through the State Legislature.

"Meantime, the number of hardship cases increases," Miss Fleming points out.

"After teaching thirty years to obtain maximum retirement benefits, many are prohibited from working because of illness or simply because of age.

"A number, plagued by large medical bills or other unforeseen expenses, have been forced to move into dingy, substandard living quarters and get by on a drastically curtailed standard of living."

The inflationary pinch has also been felt by employees enjoying more liberal pension plans.

Robert Schurig, sixty-four, of 9951 Stoepel, retired after thirty years as a Detroit fireman, draws a \$177 monthly pension.

Since he is entitled to half the pay currently earned by firemen in the classification he held before retirement, he is partially protected against rising prices. Pay hikes granted firemen since his retirement in 1944 have been reflected in his pension.



YOU BUILT IT !

"Good Morning, Doctor. I represent *your* Blue Shield."

Twelve years ago, you, the Doctors of Michigan, built a vehicle. A means for pre-paying medical-surgical care. The present status of Blue Shield as a social institution was obscure twelve years ago. The vehicle has changed with the times, and is changing each day. Social institutions must keep abreast of the age. The machine is yours. You built it. To merely drive a vehicle these days is not enough. Motors and design are not infallible. A gear is only as strong as its pinion. One must know how the machine works. And when a Professional Relations Representative greets you with "Good Morning, Doctor. I represent *your* Blue Shield.," he is bringing the vehicle you designed and built to you.

Shakespeare once wrote, "It is a wise father that knows his child." When this quotation is applied to the thesis here, the father becomes each Doctor of Medicine in the State of Michigan—The Michigan State Medical Society. The child, their child *your* child is Michigan Medical Service.

The environment out of which professionally managed pre-payment plans arose was both factual and theoretical. The first entry on the factual side of the ledger was the depression and the period of economic stagnation during the decade of the

thirties. The alphabet agencies of the federal government sprang up over night. The WPA, the CCC, and others became as close to the population of the country as the BVD. Only historians will be capable of judging whether or not the economic burden of the country was alleviated through this means. The point, however, at the time was that the government would and could cure all of the economic and social problems which faced the country as a whole. And one of the most acute problems was the matter of hospital and medical care for millions of Americans who were unable to meet the costs of such contingencies.

For many of the people in the country there was but one answer. There was but one place to seek the refuge they had already found through governmental agencies the federal government, of course. This feeling of dependency on the part of many toward the government prompted the seed for governmental entry into the hospital and medical fields. Social planners were quick to grasp at the opportunity.

Hospitals were the first to feel the rumblings of the storm. Prior to the Great Depression a majority of the hospitals were privately endowed. Citizens of a community who were able to underwrite the deficits of an institution rallied to the appeal of the hospital. The depression ended that. The pressure on the hospital was at a peak. The doctor felt the repercussions directly. He could pull in

YOU BUILT IT!

his belt. The hospital had no belt to tighten! It needed to do something and quickly!

Without the flurry and confusion that sometimes accompanies the solution to a problem, the hospital merely adopted a gimmick that was prevalent around them. Furniture stores, appliance stores, and almost all types of real goods were being sold on an installment plan. A buyer was able to pay for a commodity a little at a time until the full bill was paid. Why couldn't this same principle be applied to hospital care? The answer, with only one modification, was affirmative: it could. This could be done if people were to *pre-pay* their hospital care. The very nature of the hospital as an institution required such an arrangement. The nature of an illness demanded prepayment and not post-payment. Here was the answer the hospitals themselves gave to government control. Here was the answer the hospital themselves gave the people of the country who realized the probable necessity of hospital care and also realized their difficulty to pay for such care.

Superimposed on this factual achievement of the hospital during the decade were the advances made by the medical profession. The entire population of the country was awakening to the fact that medical care is the only human necessity, the need for which cannot be predicted in advance. Even today, during a period of rising costs, it is easy to estimate with accuracy next month's cost of food, of clothing, of rent and every other necessity, save medical care; and no one can predict this even 24 hours in advance. This idea was emphasized during the early thirties. An idea which affected every human being in the country.

On the factual side, too, the medical profession made advances. The fruits of science are not concerned with price tags. The researcher found more and more an application for the knowledge he was gaining in the laboratory. Where, for example, during the twenties ten diseases out of fifty could be cured, the thirties found forty cures for the fifty specific illnesses. Doctors urged patients to utilize the facilities of a hospital. It was the hospital, and only that institution, which housed the mechanics and progress the science of medicine was developing. Utilization of hospital care doubled, trebled, and in many instances more fantastically multiplied. Where the doctor of the twenties needed the hospital for his work, the doctor of the thirties found his patients asking for hospital care where they knew each facet of the medical sciences would be available.

The medical profession found itself in much the same position as the bear hunter who was being chased by a bear. He finally climbed a tree and as he looked below he saw the bear coming toward him. He was a man not given much to prayer but he thought this was a good time to pray. There is

no sacrilege intended in this, but his prayer went something like this: "Oh God, if I ever needed help, I need it now. Come help me and don't send a little angel because this ain't no boy's job."

It was a complex situation. The elements were all so closely interrelated that it was difficult to think of hospital economics without thinking of medical economics. Science advanced rapidly; the people were aware of the advances. The hospitals had done something about meeting the individuals' needs. The rumblings of governmental control were quieted on one front. But on the other front, the medical profession's job was a man-sized one.

Studies, special committees, and an earnest interest from almost every doctor in the country aroused the profession on a national scale. As early as 1931, a survey on the cost of medical care was made by the Michigan State Medical Society. One year later the Hoover Committee Report on the Cost of Medical Care was published. Here were two tangible points of departure. Here was the need for some financing plan made specific. An increasing number of physicians were convinced that it was to their best interests as well as the interests of the nation that some plan be developed. A form was beginning to take shape out of the seemingly endless dark. In 1939, the first statewide medical care prepayment plan squalled its then weak voice at the tremendous job that needed to be done nationally. Was this the solution to the problem, or was it an attempt in the direction of the impossible. Just one year later, in 1940, the Michigan State Medical Society embarked on its prepayment "experiment."

It needs to be emphasized that the "experiment" which began in 1940 was not the result of any one or two doctors in the State of Michigan. On the contrary, this was the result of *all* the doctors in the State . . . this was the result of the Michigan State Medical Society as a whole. The result of a group who faced a common situation.

Ideas need to be crystallized. They need to be tied together, modified and moreover they must meet the need for the situation at hand. Few men are able to crystallize ideas well, but the Michigan State Medical Society members were a lucky lot. Leaders developed. These men were of that vintage of man who are leaders of idealism. They did not work within that framework of fantasy which so many thinkers in the realm of idealism find themselves vaguely and abstractly imbedded. They were not revolutionaries. They were not impractical. These were men who could see at first hand the needs of their patients. These were men who could gauge the reaction of other doctors and the needs of the time.

When the matter began to jell they felt that the people of Michigan needed a complete program.

YOU BUILT IT!

A program which would guarantee them the cost of medical care whether they needed that care in a hospital, or in a doctor's office, or in the individual patient's home. People needed to be guaranteed the payment for medical-surgical care whether that cost was low or fantastically high.

A sound venture revolves around statistics and actuarial data. The Society was embarking upon a type of insurance program. But there was a difference. Where an insurance company tries to gauge its risk, there was no gauging to be done in the case of medical care. Let's take, for example, a man that dies at the age of forty. The payment from an insurance company does not attempt to pay the beneficiary the total amount of income this man could have earned if he had lived. The devastating cost of medical care must be met. In reality, there is no means of even guessing a partial payment. This needed to be complete coverage. One that did the job and did it in its entirety.

The plan which was put into action in 1940 offered an all-inclusive medical care program. Medical services rendered in the patients' homes, the doctors' office and the hospital were covered. The coverage was complete in every respect. Through sheer speculative calculation, a monthly subscription rate was established.

When one assumes the role of a pioneer, hardships must follow. The two go hand in hand. They are inseparable. And where does pioneering lead? What becomes of it all? These answers are lost in the abyss of time. Look at the visionary who predicted that some day the horseless carriage would be a necessity. Pioneers in automobile manufacturing were ridiculed. The airplane would never be a success. Television was a pipe dream. Today, many of us smile at interplanetary travel as yesterday we laughed at atom splitting. The visionary believes he is not working with the impossible.

Those early years of the Medical Society's prepayment plan in Michigan were not easy ones. Disbelievers jeered and obstructed. The program was hampered by inadequate finances. The subscription rates barely covered half the cost of the idealistic plan. This would never work, people said. It was an attempt toward accomplishing the impossible, others pompously remarked. Yet there were those who did believe. Those of stout heart and keen interest. The struggling years of the early forties are history now. The breath of life many gave the faltering child will never be forgotten. And certainly the impetus, inspiration, and concern from the Michigan State Medical Society marks a brilliant chapter in that Society's history.

Practical considerations have necessitated change in the basic philosophy of a professionally sponsored pre-payment medical-surgical plan. The

public was in dire need of a program that would protect them from the financially disastrous medical bill. The hospitals were aware of the fact that a vast majority of people could meet a small hospital bill. It was the catastrophic bill that would require the mortgaging of a home, the borrowing of money at usury rates that could break the morale of a family. Practical, efficient, business-like principles needed to be adopted by the doctors for their plan to work. And this was done. This was done by the Michigan State Medical Society, by the doctors of Michigan. The necessity was faced and the Doctors joined together to meet it.

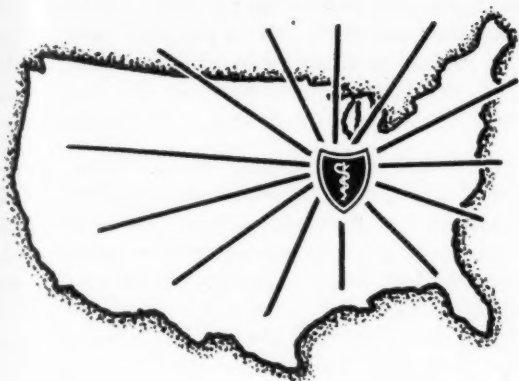
During this period of the development of Blue Shield here at home one must not lose sight of the spontaneous reaction that was taking place throughout the country. Some State Medical Societies were slow in recognizing the need for a professionally sponsored program. Where this was true, county societies answered the call. Doctor-sponsored prepayment plans were cropping up all over the nation. They were greeted with public approval. This was no longer an "experiment." Rather, the voluntary prepayment method of medical-surgical care sponsored by the profession was rapidly coming into its own.

Statistics in themselves are usually cold. One seeks to dramatize them as much as possible. If one were to say that well over twenty-two million people in the country today have Blue Shield protection, the fact falls flat. Yet when you can say that more people in the past twelve years have enrolled for Blue Shield protection than have been born in the past six years, then the fact takes on stature. Or when you can say that more than four times as many people enroll for Blue Shield each day—an estimated 23,000—than there are automobiles produced in the country each day, the fact becomes more meaningful. Last year alone more people enrolled for Blue Shield nationally than there are legal residents in eight states in the country. Already seventy-eight separate Blue Shield Plans are sponsored by State Medical Societies or County Medical Societies throughout the country. More County and State Societies realize the need for such a program each year.

Here at home we have something to be proud of. For some time during the period of national development, the Michigan Blue Shield Plan had two-thirds of the total nation-wide enrollment. Ever since its inception, the Michigan Plan has led the nation in the total number of people enrolled when compared with any comparable area.

Why, you may ask, has this seemingly stop-gap measure been perpetuated? Was it not of economic crisis that the idea of pre-payment medical plans evolved? Let us try to find the answers. Just a few paragraphs ago we mentioned the auto-

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motive pioneers who tried desperately to come up with a necessity . . . something that the public could not presumably do without. Look at those pioneers who set down their mechanical means of transportation. Was there any way of measuring that someday the automobile would become almost a necessity? Absolutely not. And the refrigeration engineer who dreamed of a majority of the homes in the country having electrical means of refrigeration, was there a way he could judge the realization of his dreams? Again, a resounding no. Granted that the circumstances surrounding the development of hospital and medical prepayment plans were somewhat remote from these other steps, yet there is a definite similarity. Principally, today as twelve years ago, the growth of Blue Shield on the local level as well as on a national scale reduces itself to the matter of a necessity. You, the doctors of Michigan, produced a product which was a hidden need. As the automobile and refrigerator, you found another vital development in social progress.

During the 1930's when the problem of economics required thinking in terms of a prepayment plan, the matter of necessity, from the doctor's point of view, was paramount. A method needed to be developed to quiet the social extremist, but more important, a plan needed to be developed because the public wanted it. The reception of the Plan was by no means an accident. Nor is the present-day reception of the Plan merely the coasting of that initial push. In reality, the Plan you developed out of necessity has evolved into a necessity for the entire country. Whether the medical profession realizes it or not, and surely they do, a tremendous educational job has been done on the people of this country. Through the years, and more and more each day, people are becoming acutely aware of the highly specialized and technical advances that are being made in the field of medicine. And at the same time, the people are becoming more aware of the need for protection against the costs involving the progress made in the field. The hospital has become, and rightly so, the workshop for the medical practitioner. As

a development is made in the science of medicine, the hospital looms larger and larger as a place to house the mechanics of that science. Whereas the doctors of the thirties developed a plan for the prepayment of medical-surgical cost because of their necessity, today the people of America realize the need for such a plan.

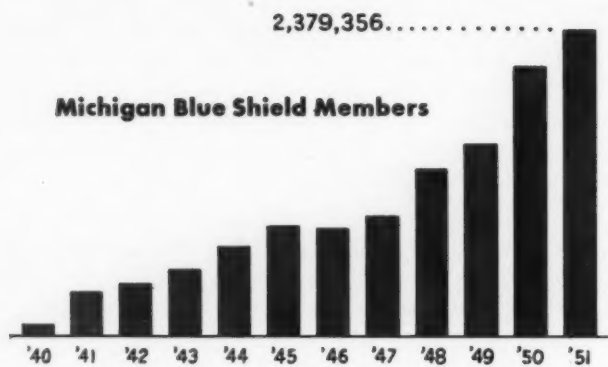
Unknowingly, a social institution was begun when doctors met the needs of the public through Blue Shield. A public trust was established. The late Senator Arthur Vandenberg put it this way: "You have done something in Michigan that you didn't know you were doing. You have established a public trust. . . . You have taken millions of dollars of the people's money and have used it for the benefit of the people. As such you are the trustees of a public trust!" The shifting of the necessity at first seems unbelievable, but in reality it is a fact.

The rumblings of the socializer cannot be overlooked. They have not died. To think that the fight has been won would be fatal. The answer to these "gimme" believers twelve years ago was an experiment; today this answer is real tangible evidence. Your Blue Shield, its present stature, its potential, its constant supervision by each and every doctor in the state, affords the greatest weapon when encountering the social regimentor on the field of battle. Here is a dynamic public necessity operated, sponsored, and governed by the doctors for the welfare of the people. Here is a functioning organization, no longer a nebulous idea, which is meeting the needs of the American public each day. Here is an organization founded on sound business principles. And here is a movement with vision enough to realize that there is still a tremendous job to be done in the field of protection against the cost of illness.

"Good Morning, Doctor. I represent *your* Blue Shield Plan. . . ." This is a Professional Relations Representative seeking to acquaint you with the operations of the Plan, progress of the Plan, and to help you better understand the coverage Blue Shield offers its subscribers. The Representative seeks your counsel, your guidance, your help. He brings your organization to you . . . bringing a child to its father.

Sometimes the most obvious justification for existence is the most difficult to set down. When one asks the question, "Why an entire department of Blue Shield designed to handle Professional Relations?" a flurry of reasons immediately come to mind. Yet there is one obvious and imperative reason which foreshadows the rest: A Professional Relations Department is necessary to form the bridge between Doctor and Plan. Good working relationships with physicians are essential to the success of Blue Shield. Blue Shield belongs to the doctors and to separate the two would be impossible.

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It needs to be emphasized again that the Professional Relations Program is essentially concerned with bringing the working of his (the doctor's) Plan to the doctor. In 1947, at the Annual Conference of Blue Shield Plans a statement of principle was adopted which clearly established the dual responsibility for cultivating good relationships between a Plan and its sponsoring physicians. In part, that principle stated:

"It shall be recognized that the responsibility for maintaining physician co-operation must be shared by plan management and the sponsoring medical society; that while plan management shall be held responsible for furnishing full information to the medical profession regarding its operations and development, the responsibility for gaining professional acceptance of the philosophy and principles of prepaid medical care shall rest essentially with the physicians and their organized societies . . ."

One must immediately pose the question, "Why a dual responsibility?" The answer lies in cold logic. The Plan was originated, sponsored, and approved by the medical profession. It was the profession's machine. From its very beginning the operation of the plan needed to comply with certain policies established by the medical profession. Consider an automobile engine, it needs its transmission to function. The transmission of a Blue Shield Plan is each doctor in the area served by the Plan. The machinery of the doctor, Blue Shield, cannot operate without him.

Further, if a medical society assumes the responsibility for establishing a Plan, it should likewise accept a portion of the responsibility for securing the active co-operation of each physician in the Society. This the Michigan State Medical Society has realized. The Society, as a whole, realizes that the essence of their plan lies within each individual doctor and his understanding of the Plan. Such co-operation is essential if the Plan and its subscribers are to exist together.

The physician responsibility consists of a moral obligation to support the economic device he has aided in establishing. And here emerges another important reason for the existence of a Profes-

sional Relations Department. Blue Shield, as an organization, does not sell a tangible item. There are no assembly lines or shipping stations in the Blue Shield office. Their product is security. And within this abstraction revolves its functions.

Security is an interesting word. Connotatively the word has a great number of applications, but denotatively, as Webster put it, the word means, "... A feeling of or assurance of safety or certainty; freedom from anxiety." This is the product Blue Shield sells its subscribers. The millions that have enrolled, and the millions that will enroll for the protection are sold a promise. A promise to each enrolled member that the benefits which are outlined in the Certificate will be carried out when and if he, the member, requires the care. You, the Doctors, fulfill that promise; Professional Relations Representatives try to interpret that promise to you.

Perhaps many doctors are saying at this point, "Well, all I have to do is read the Certificate issued to subscribers and I'll know what is expected of me!" No truer words were ever uttered. Yes, this acquaintanceship with Blue Shield is imperative. But there's just no sense in kidding ourselves; very few people read their own life insurance policy, or fire insurance policy, or even their automobile insurance policy. And even if we can honestly say that we've read all of this literature, there is more to your Blue Shield than merely understanding benefits. If we can arrive at one truism in this discussion let us attempt it now: A well-informed doctor means a well-satisfied public.

And this brings still another reason for Professional Relations. How can the physician's organization function properly and effectively unless the physician is there to steer its destiny? Blue Shield needs the advice of the doctor . . . each doctor in the state . . . to make it realize its shortcomings and discrepancies. An artillery commander never knows where his shells are hitting—on target or miles away—without the aid of an observer to direct him. This is Blue Shield without the help of the doctor. An organization which has no way of knowing if it is hitting the bullseye of public approval, and certainly never knowing when it is off target, can in a short while burn itself out. Blue Shield, developed by the doctors twelve years ago, could not have survived the gaff if doctors had not directed. The strength of Blue Shield in the years to come rests entirely with the doctor . . . you . . . and the guidance, interest, and direction you offer.

Organized Professional Relations was a neglected important cog when the machine was built. Of course there were sessions with doctors explaining how the machine they had built was running. And of course there were "fires to be put out" all over the state. Fires that threatened the existence of the Plan only because men did not understand

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its function. It was not until a young-looking, slim, ex-Army Corporal began working in the Blue Shield Claims Department that the tremendous problem of Professional Relations was approached.

Few men are able to come upon a situation and analyze it. Still fewer men have the capacity of writing or detailing the prescription that can solve a problem. John Castellucci was hired by Blue Shield in 1943 and assigned to the Claims Department. Here at first hand he was able to see the wheels of the machine in operation. And here his keen analytical mind set to work.

Why was he having so much difficulty processing a Doctor's Service Report? Why were the reports improperly filled out? Why were the doctors lax in understanding the processing of their payments in the office? And why were the doctors not understanding how their organization was working? These were the questions that kept bothering John. They were the questions that needed answering from the Plan's point of view. His reasoning went something like this: These doctors are all intelligent men. They have recognized the need of the public through the establishment of a method of pre-paying services. The doctors needed someone, something, some real means of having the mechanics of a business—their business—explained to them.

The problem was there. To write the prescription for its solution was difficult. But to compound the prescription in correct proportions was still another matter.

Castellucci went to Charles Coghlan, then director of the few field men who were "putting out fires," with the problem, solution, and means for activating the answer. The problem was obvious. The inventors of the machine had lost touch with their brain child. The machine was running, yet the men who built it were not aware of the difficulties it was having. This could not continue. Without the doctors' knowing more about their Plan the pre-payment method was in serious trouble.

The Plan had to be taken to each doctor in the state. It was theirs and no one else's. Its existence depended on them. They built it. They had to know how it worked. Instead of "putting out fires" when they broke out, John proposed a means of averting the blazes. It was all a matter of telling each doctor of his own vehicle. Explaining to the physician the vastness of the problem, and, moreover, seeking the doctor's advice on how to correct problems.

John likened the situation to the executive branch of government. "The Plan is the executive branch. The judicial and legislative branches are the doctors themselves. We must get to them and hear them. We're not policemen of the profes-



JOHN W. CASTELLUCCI, Assistant to the Director, Michigan Medical Service

sion, nor are we the profession itself, we belong to them and we must understand them. They're the bosses. We must listen to each of them." Here was the essence of the very future of the Plan. To activate this idea would not be a simple matter, yet Castellucci is not of the brand that backs away from a seemingly insurmountable problem.

There was only one way to do the job and do it properly: See the doctor—each doctor in the state, personally—and explain Blue Shield to him. See him wherever one could, in his office, at Society meetings, any place. The point was, see him! John tells of playing eighteen holes of golf with a physician on a blistering July Sunday afternoon. The doctor was an excellent golfer, measuring each shot and exerting great effort in playing a "scientific" game. It was John's very first experience with golf clubs and a golf course. "I dug up the turf, sweat, strained and had a strenuous day. But the Doctor loved giving me some pointers and we had a wonderful time together. . . . I wasn't able to get out of bed for two days after that. But I had talked to one doctor and he understood Blue Shield. It was worth it!"

The prescription was working. Doctors were contacted, changes were made in office procedures, modifications were made that originated with the doctors themselves. And doctors appreciated the opportunity of being active in their own Plan.

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They, of course, were aware of Blue Shield and their relationship to it. But having a Blue Shield Representative visit with them so that they could discuss the Plan in its entirety was something new, and something that the doctor himself was overwhelmingly in favor of. At first, field representatives were looked upon skeptically, yet when their mission in the doctor's office was explained, a warm welcome was apparent.

Just as the Professional Relations Program was coming into its own, another related problem developed. It was 1945 and veterans of the War were beginning to return to their homes. Many of them had service-connected disabilities. Was it impossible for Blue Shield to handle these veterans? The doctors thought it could be done, and after weeks of planning, a task force was sent to Washington.

John went along, assigned the job of trying to reduce the required government paperwork and red tape to a minimum. He found himself in a difficult position. Here was John, an ex-Army Corporal, talking with Colonels, Generals, and Admirals. He remembers distinctly pounding on the table to emphasize a point at one time during the conferences and having a Colonel remark, "My, if those chevrons were only on your sleeve now!" But the task force returned to Michigan with a victory. The paperwork was reduced from eight pages to one page for each report. The plan was much too logical for even the Veterans Administration to refuse.

When that eventful trip was finished, the Blue Shield Plan in Michigan was to handle veterans medical care on a local scale. The program worked beautifully. Blue Shield Plans throughout the country refer to the program as the Michigan Veterans Care Program, and today this Program is still doing a remarkable job as an integrated part of *your* Blue Shield.

With the Veterans Program running smoothly, John was anxious to get back to his Professional Relations work. There was still a large job to be done. The field work program needed to be expanded and new people in the work had to be well grounded in their task. Each of them had to know the internal operations of Blue Shield. They had to know about Blue Cross. They had to realize that they were not salesmen. They weren't selling a thing to the doctor, but rather their sole purpose was to explain Blue Shield to the physician, get a feeling of his thinking about his own prepayment program, and answer questions the doctors had about the status of the Plan. The job was unending.

As John again became engrossed with the Professional Relations Department here at home, the Blue Shield Commission in Chicago flicked a beckoning finger. This matter of contacting phy-

sicians was working in Michigan, and other Blue Shield Plans in the country desperately needed a program like it. The eyes of Blue Shield Plans throughout the country were focused on this new idea which was evolving—the idea of the doctor becoming a more integral part of the economic necessity he had created. John was "loaned" by Michigan to the Commission late in 1947 on a part-time basis. He retained his capacity here with the Veterans Care Program and Professional Relations.

He was to visit other Blue Shield Plans throughout the country and explain the Professional Relations Program Michigan had adopted. When he was approached with the proposition the Commission had to offer, he insisted that he remain in Michigan on a part-time basis and only work with the national picture on a split schedule. He was so vitally concerned with physicians running their Plan that any other project would have surely been refused. But seeing the necessity for a well organized Professional Relations Program here and realizing its importance nationally, John felt that if other Plans were to adopt the program they would run more smoothly. Then, as now, Blue Shield was lost without the Doctor.

John became part-time Assistant Director of the Blue Shield Commission. He traveled all over the country explaining the Professional Relations Program. Difficulties were mounting faster than the Plans could handle them. Most all of the difficulties came from the lack of co-ordination between Doctor and Plan. Plans had some Professional Relations and didn't know it. Certain men of each Plan spent time talking to doctors, but the difficulty came from their lack of teamwork. Each Plan had field men talking to doctors and listening to complaints, but most of them failed to recognize constructive ideas when the doctor presented them. Castellucci changed most of this. Plans were shown how Michigan was handling the situation, and some basic philosophy of Blue Shield was reviewed. This was the Doctor's Plan. They had to know how it operated. They had to help operate it.

John talked loud enough and long enough. Many Plans all over the country set up a Professional Relations Department patterned after the Michigan program. They were programs that were responsible directly to the Plan Director and in turn, the Board of Trustees. Again, Michigan had set the pattern. It would have been futile for a Professional Relations Program to get lost in the obscurity of other office procedures. Doctors had to know that the Professional Relations Representatives that talked to them would get their information, suggested modifications, and gripes to the apex of the organization. It went directly from the doctor to the place where it would do some good.

YOU BUILT IT!

Castellucci returned to his office in Chicago and began writing a manual for Professional Relations that could be used all over the country. Meanwhile, here at home Professional Relations did not sit dormant. In 1945, L. Gordon Goodrich, just returned from the Navy, was appointed Assistant Director of Michigan Medical Service. Part of his duty was to direct the program. Great strides with Professional Relations were made while John was "spreading the gospel." Personnel was added. The state was proportioned into areas in which specific contact people were to work. Doctors were becoming interested again in their pre-payment program. But more emphatically, the Plan was beginning to get the suggestions and advice of the physicians in a steady flow. We used the allusion before about the artillery commander not knowing where his shells were hitting. The doctors in Michigan began telling Blue Shield about its deficiencies. The doctors were telling Blue Shield how far they were missing the target in many instances. This was good. This was what the Plan needed. Sights were re-adjusted.

Make no mistake at this point. The primary objective of the Professional Relations Program is to explain to the doctor the workings of the machine he, the doctor himself, created. On a very real plane, the contact person attempts to show why certain procedures are necessary for sound operation. Sure, Doctor Service Reports are sometimes cumbersome to complete. Granted there are sometimes delays in Blue Shield payments. Certainly there are times when the machine just doesn't work smoothly. Yet the machine *can* run smoothly. The motor can hit on all pistons if the other gears are meshing properly. You, individually, are those other gears. The Professional Relations Department is merely the mechanism which greases the gears and tries to make the motor operate evenly.

This, basically, was the concept Castellucci put into his Professional Relations Manual which was published in 1950. It has become the standard text of Physician Relations throughout the country. Doctors had to know the inner workings of Blue Shield. This was essential. When each doctor in an area could see how his Plan operated, then and only then would Blue Shield be doing the job the doctors originally intended for it to do. When the doctor knew his Blue Shield Plan, the public would know it as well.

Castellucci's work with the Commission was at an end. He returned to Michigan Medical Service on a full-time basis in July of 1951 to put into practice some of the ideas he had formulated concerning field service for Blue Shield. He came back to Michigan on a full-time schedule convinced other Plans in the country would begin organizing field forces. He was convinced the Plans, too, would be keeping a keen eye on the Michigan program and its development.

John came back to Michigan and the Professional Relations Department was his again on a full-time basis. His sleeves were rolled up. There was a job to be done.

Many things needed to be explained to doctors about their organization. The keystone of Blue Shield needed to be reiterated over and over again. The Plan had evolved from a means of covering and protecting the public from the costs of every phase of medical treatment. This had changed and doctors needed to know why Blue Shield and Blue Cross had become a means of protection—because the public wanted it so—that protected a family against the financially disastrous hospital and medical bill. The basic philosophy of the two had become the same. They were identical from a primary approach. Doctors had to know it. And when a doctor got a patient that demanded hospital care because he felt it was "coming to him" as a Blue Cross-Blue Shield subscriber, it was the doctor that was responsible for the explanation. It is a dominant factor in human nature to "get what's coming to us," and this attitude in itself could spell disaster for both pre-payment plans. One affects the other directly. Doctors had to be aware of it. Professional Relations people had to tell them about it. When the doctor understood only a few fundamental facts, then both Blue Shield and Blue Cross would become stronger and more vital to the profession, the hospital, and the public.

This was the problem as John saw it all over the country. Getting to the doctors of Michigan and having the opportunity of re-emphasizing these basics was essential. It was a big job and one that only a few could not accomplish.

More personnel was added to the department supplementing those field men that were already on the staff. Today there are eleven men and two women that are field representatives for the Plan.

In September of 1951, John's staff was strengthened by Louis H. Freye, four-time member of the Michigan State House of Representatives. Keen of mind, likeable from the beginning, and thoroughly interested in the Blue Shield program, Freye was appointed Representative-at-Large to cover the entire state. His interest in the Doctor-Plan relationship is one that can be traced through his entire career. "I've spent many years of my life with the Boy Scout program in this state (he holds the Eagle Award and the Silver Beaver Award) only because I can see the value in building a strong country through a strong youth. The same can be applied to Professional Relations work. A strong Blue Shield can result from an informed Doctor. The work seems analogous." His work throughout the state in just the short time he has been associated with the Plan bears out his interest and the importance he feels lies within the program.

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LOUIS H. FREYE, Representative-at-Large

"Louie" was born in Muskegon and has resided there all his life. He studied pre-law and received his certificate of education from Muskegon Junior College. He was a member of the Michigan State House of Representatives for four terms, resigning during his fourth term to take up his work with Blue Shield. His work with the Boy Scouts both here in Michigan and nationally has been outstanding. His awards include the Eagle Scout Award, the Scoutmasters Award, the Scoutmasters Key, and the coveted Silver Beaver Award. Louie was appointed chairman of the Michigan Veterans Facility Committee while a member of the House. He was the first non-veteran to serve on the committee and has been the only non-veteran ever to be appointed chairman of the group. He is married and has two sons.



WILLIAM H. BYRNE, Assistant Manager, Professional Relations Department

Bill was born in Detroit and has lived in that city all of his life. He attended Assumption College in Windsor, Ontario, and graduated from that institution in 1936 with an A.B. degree in history. After leaving college, Bill worked for an automobile insurance company in Detroit doing claims adjustments. After five years at this work, he came to Michigan Medical Service when the organization first began. His duties were comparable to an Office Manager. He was responsible for internal office procedures. Bill left for the Army in 1943 and was a classification specialist and vocational counsellor for two and a half years. He returned to Blue Shield as a field representative in the Port Huron area. His present position was made available to him in July of 1951. He is married and has no children.

Most doctors in Michigan know that when they have a Blue Shield question their Plan is as close to them as the nearest phone. This is good. And when a question is asked of a Blue Shield field man he can usually answer it, or if not he finds the answer. Questions of payments, benefits, the Doctor's Service Report, x-ray benefits, and many others are the routine problems which face most physicians. Yet to the Professional Relations man there is one very important idea he wants to tell

each Doctor. An idea that is vital yet vague to so many in the profession: Doctors in the State of Michigan have two professionally sponsored organizations. The Michigan State Medical Society is an ethical, scientific, educational organization. Blue Shield is the administration of a corporation rendering a public service. Each doctor in the State should know Blue Shield as well as he knows the Society. Both are his.

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At the last meeting of the MSMS House of Delegates a Liaison Committee was appointed to work with the Blue Shield Professional Relations Department. The Committee was geographically selected so that the field men in each area (see following maps) would have a Doctor to go to with problems and questions the representative cannot handle alone. Specifically, the Liaison Committee's functions are:

1. Serve as a source of reliable information about the Plan for the physicians in the area.
2. Refer to the Plan all complaints, criticisms, or problems arising among the physicians.
3. Interpret subscriber reaction concerning coverage to the Plan.
4. Work closely with the field man in the area to promote wider public acceptance of the Plan.

Blue Shield openly welcomes any means that will maintain a close relationship with its source, the doctor. The contact people know this. If there is one idea emblazoned in each of their minds, it is to establish thorough understanding between doctor and Plan. The field man does not want to sell you, the doctor, a thing. In reality, he has nothing to sell! He's not a salesman. His sole reason for existence as a Blue Shield employe is to create a mutual understanding between your Plan and every physician in the state.

Doctors are extremely busy men and Professional Relations Representatives are aware of it. He still tries to see the doctor in his office, but has also found equally effective places where the doctor is able to talk with him. He sees the doctor in cloak rooms of hospitals. He sees you at County Society meetings. He talks to your secretary or nurse explaining Blue Shield forms. He sees you at Medical Conventions. And he has seen some of

you in classrooms before you graduated. These have all proven to be valuable avenues of information. It's you, the doctor, no matter where he sees you, that the Representative is anxious to talk to. It's you that govern the Plan. It's you that must know how it works. It's yours.

To relate some of the questions field men are asked in one typical day would be futile. None of the inquiries is irrelevant. None of the questions doctors ask is unreasonable. All of the questions and problems doctors have concerning Blue Shield have an answer and solution. The field men are there to answer the questions. Together you can solve the problems.

Facts speak for themselves. The nebular idea you, the doctors of Michigan, had twelve years ago is no longer merely a dream. The idea has evolved into a reality . . . a social institution . . . a necessity for millions of Michigan residents. The words of Senator Vandenberg ring truer each day. You have created a "public trust." You have created an accepted method of pre-paying medical services. The management and proper handling of this method is the responsibility of the doctors themselves. It is only through a close relationship between doctor and Plan that the method can function properly and with the utmost effectiveness. The responsibility is yours!

For many doctors in the state, Blue Shield is no longer the light in the darkness of the thirties when the social planner feverishly ranted the need for governmental control of the profession. And, on the other hand, many physicians have forgotten how desperately the public needed some means of medical cost protection. Many have forgotten that it was their own organization, their very own program of Blue Shield, that offered the light in the black period. Forgetting is easy. But the doctor must be aware of the necessity he created. He must realize that *his* Blue Shield has become a public trust. He must realize that the people of America need Blue Shield today even more desperately than they did years ago. The people are aware of it. Thousands each day enroll for the program. Today, the necessity is theirs. If the voluntary, professionally sponsored pre-payment programs collapse, the socializer will again have an opportunity to force his issues. This must not happen; Americans don't want it to happen! Through your interest and understanding of Blue Shield you can avert the collapse. Professional Relations Representatives bring the workings of the Plan to *you*. Understanding the Plan individually, you strengthen the Plan collectively. You have built a vehicle, a necessity. It is doing a job. It still has much to do. The strength of that vehicle is in *your* hands.



MSMS LIAISON COMMITTEE meeting with the Michigan Medical Service Professional Relations Representatives



THESE ARE THE PEOPLE

To discuss Blue Shield, the Professional Relations Representatives and their function is one thing, but to acquaint you with the Professional Relations Representative in your area is another matter. On the pages which follow, the Professional Relations Representative and the Liaison Committee member for each area in the state are pictorially presented.

But before you flip to the next page, consider some of the people who operate Blue Shield from an internal basis. These are the people you may never meet. It's altogether possible that you have received a letter or a check, or perhaps even talked with some of these people over the phone and have often wondered, "Well, I wonder what that guy looks like!" Here's the opportunity to see for yourself.



THESE ARE THE PEOPLE THAT BEGIN THE PROCESSING OF YOUR SERVICE REPORT. Over 2,000 Doctor's Service Reports are received in the Blue Shield Mail Room each day. That averages about 48,000 a month!



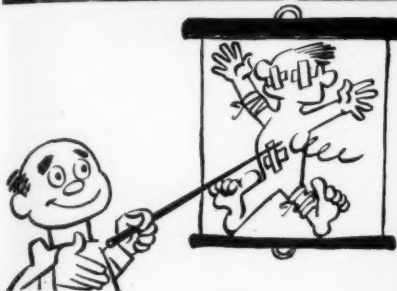
THEY TRY TO READ YOUR WRITING . . . One of the first steps in processing your Report for payment is to code your name with a number. But one must be able to read the writing first!

THESE ARE THE PEOPLE



THE PATIENT MUST BE IDENTIFIED, TOO! This group of young ladies attempt to verify the member's eligibility for the services you have rendered him. Actually, Blue Shield has over 13,000 Smiths enrolled . . . some fat, some short, some thin, and some tall.

When you receive a letter asking for more information concerning a patient, that inquiry originated here.



C. D. Moll, M.D., Medical Director, and Edward J. Reilly, Chief Examiner, with a staff of twenty-five give your Service Report the individual attention it deserves. If your report is a routine procedure the examiners record the amount Blue Shield will pay you for the service. When a report is of a more complicated nature it is referred to the Medical Advisory Board.



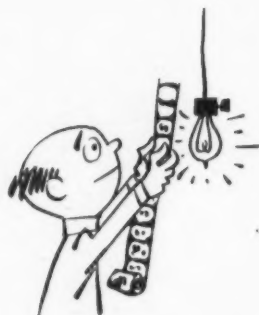
Robert Henshaw, Assistant Treasurer, is responsible for your check being completed. With the aid of a battery of International Business Machines, over 1,000 checks an hour are written to Doctors.



THESE ARE THE PEOPLE



STATISTICS ARE OF VITAL IMPORTANCE. And it's Henry Hosmer's job (Chief Accountant) to keep accurate ones. Recording of utilization, payments, and other disbursements are of vital importance to the stability of the Plan.



THEY PHOTOGRAPH YOUR SERVICE REPORT. Because the records must be stored for an indefinite period of time, of course space is at a premium. With a microfilm apparatus, the space involved for storing these records is reduced tremendously.



TELEPHONE INFORMATION CENTER. These young ladies answer over 2,000 phone inquiries concerning Blue Shield each month. The question that is most frequently asked by subscribers is "How much did Blue Shield pay my doctor?"



Through inquiries by both subscribers and physicians, the Professional Relations Department is able to gauge the work that needs to be done.

THESE ARE THE PEOPLE



NEAL McCUE
Representative
MMS—Professional Relations



ELIZABETH NEUMANN
Representative
MMS—Professional Relations



WILLIAM BROMME, M.D.
Chairman
MSMS—Liaison Committee

ELIZABETH NEUMANN was born and raised in Detroit. She attended the University of Detroit. After leaving the University she was employed as an airline hostess on the Chicago and Southern Airlines. Betty has been with Blue Shield as a Professional Relations Representative for the past three years. Her area is Metropolitan Downtown Detroit.

HELEN SCHICK came to Blue Shield after a long and successful career with Blue Cross. She is a native of Detroit and spent two and a half years in Liberal Arts Studies at Wayne University. Helen began her work with Blue Cross as a Community Relations Representative. Helen has been working with physician relations for about two years. The area east of Woodward Avenue is her territory.

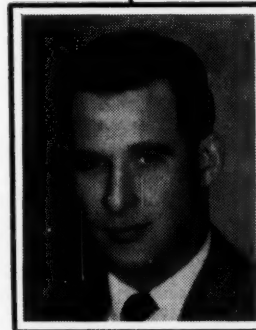
VERNE COLLETT came to Blue Shield from New York City. He has been with the Professional Relations Department for the past eight months. Verne spent five years with the paratroopers during World War II. He worked with the Judson Advertising Agency's television department writing, casting and producing nation-wide programs. He is married and the father of two boys.

NEAL McCUE was born in Goodells, Michigan and has been in Detroit for a little over a year. He graduated from Albion College with a B.A. degree in 1948 with majors in biology and chemistry. He continued his post-graduate work in chemistry at Albion. Neal spent two years with the Army Medical Corps in Germany. When he returned he was accepted to the University of Michigan Medical School but left his studies after one year. He has been in the Professional Relations Department for the past nine months. Neal has been married for a year and a half.

ALL OF THE ABOVE REPRESENTATIVES HAVE THEIR OFFICE IN THE WASHINGTON BLVD. BLDG., 234 STATE STREET, DETROIT, Phone: WO. 5-2700



HELEN SCHICK
Representative
MMS—Professional Relations



VERNE COLLETT
Representative
MMS—Professional Relations

AREA 1

Wayne County

POPULATION	2,435,235
DOCTORS IN AREA	2,996
BLUE SHIELD PAYMENTS TO DOCTORS (1951).....	\$8,304,253
BLUE CROSS HOSPITALS	54

THESE ARE THE PEOPLE



BRADLEY M. HARRIS, M.D.
Member
MSMS—Liaison Committee



WILLIAM W. BOYLES
Representative
MMS—Professional Relations

WILLIAM W. BOYLES is a native of Waukegan, Illinois. Called Bill by all those who know him, he has been in Detroit for the past twelve years. Cheerful, with a smile for every occasion, and a wonderful sense of humor, Bill finished his schooling with a major in sociology from Northwestern University in 1939.

He was employed by the Abbott Laboratories in North Chicago after graduation. How packaging pills has anything to do with sociology even Bill has difficulty explaining.

Bill saw service on three major midwestern newspapers as a reporter. His work with the Milwaukee Journal was outstanding. Early in 1941 he began his work with Michigan Medical Service and the Professional Relations Program.

He was drafted shortly after he began his work with Blue Shield and was assigned to the 101st Airborne Unit. He held the rank of First Lieutenant and received his Captaincy before being discharged.

His two sons and daughter take up most of his time. "The Kids will soon be old enough to go fishing with my wife and I. Then the five of us will really show these fishermen how to catch the big fellows!"

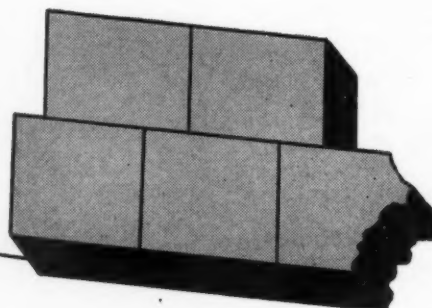
Office: 1200 Washington Boulevard Building, 234 State Street, Detroit, Phone: WO. 5-2700.

Home: 13332 Winchester, Huntington Woods, Phone: LI. 3-9601.

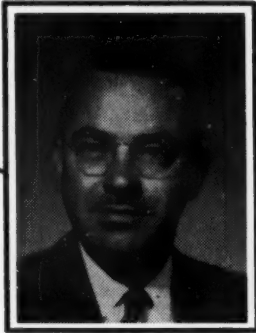
AREA 2

COUNTIES: Hillsdale, Jackson, Lenawee, Monroe, Washtenaw.

POPULATION	414,742
DOCTORS IN THE AREA	557
BLUE SHIELD PAYMENTS TO DOCTORS (1951).....	\$985,439
BLUE CROSS HOSPITALS	14



THESE ARE THE PEOPLE



G. W. SLAGLE, M.D.
Member
MSMS—Liaison Committee

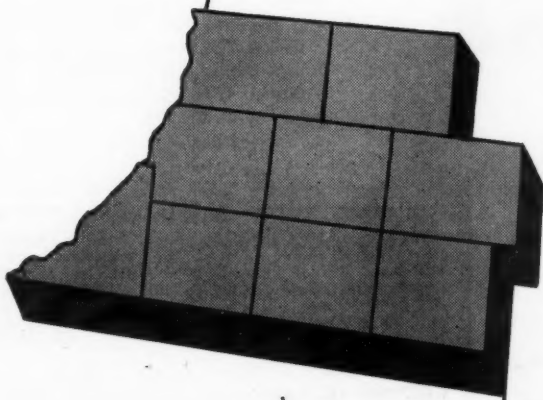


WESLEY A. BARTON
Representative
MMS—Professional Relations

AREA 3

COUNTIES: Allegan, Barry, Berrien, Branch, Calhoun, Cass, Kalamazoo, St. Joseph, Van Buren.

POPULATION	569,340
DOCTORS IN AREA	548
BLUE SHIELD PAYMENTS TO DOCTORS (1951).....	\$757,138
BLUE CROSS HOSPITALS	25



WESLEY "Wes" BARTON was born in Chicago. He attended Palmer College in Missouri and graduated with a B.A. degree in Personnel Administration from the University of Colorado.

Wes has held the position of Personnel Director of the Chicago Office of the Encyclopedia Britannica. After leaving this job he worked as a Public Relations Director for a Chicago concern and did sales work for the same company.

He joined the Chicago Blue Cross Plan as the Assistant Director in 1946, and held that position until he came to Blue Shield in Michigan as a Professional Relations Representative.

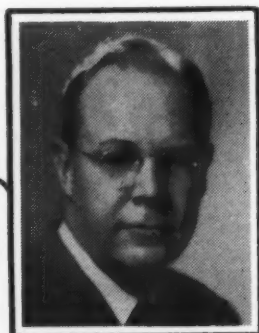
His military career was spent with the Air Corps in which he held the rank of Captain. He was an instructor and personnel officer at one of the major air bases.

Boating takes up most of his leisure time. During the winter months when it is impossible for him to be out in his boat, Wes studies current charts, depth charts, and plans his summer voyages.

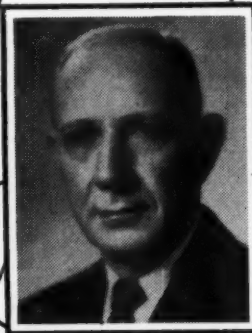
Office: 202 Michigan Avenue, Benton Harbor, Phone: 8105.

Home: Box BB, Coloma, Phone: 344.

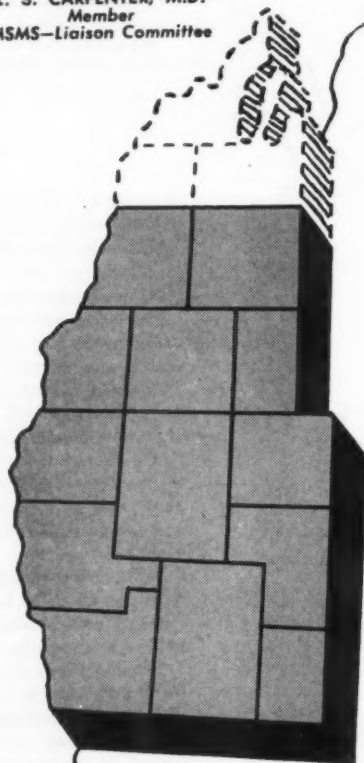
THESE ARE THE PEOPLE



L. S. CARPENTER, M.D.
Member
MSMS—Liaison Committee



GLENN WILLARD
Representative
MMS—Professional Relations



With a deep, slow, typical western accent, GLENN WILLARD came to Michigan Medical Service from Nebraska in 1951. Actually, Glenn was born and raised in Kansas where he pioneered the Blue Cross work in the state. It was 1941 when the Blue Cross-Blue Shield movement came to Kansas and Glenn was right there to give it a push.

"In those early days none of us had any special jobs. We did everything and anything in the office or out of it to make the Plans run smoother," Glenn remarks of those beginning years. He was one of the first to venture Community Enrollment for Blue Cross and Blue Shield.

His work with the Nebraska Blue Cross-Blue Shield Plan was primarily of an organizational nature. He spent three years with the plans before coming to Michigan.

Glenn is the father of four children. The oldest son is a weather forecaster and hydrologist in the West. The next oldest son is a Doctor of Medicine finishing his residency in St. Lukes Hospital, New York City.

Incidentally, Glenn is the nephew of the famous boxer, Jess Willard. Glenn tried to defend his uncle's honor a number of times and has a broken nose to prove it!

Office: 752 Keeler Building, 60 Division Street, Grand Rapids, Phone: 9-4331.

Home: 1541 Giddings, S.E., Grand Rapids, Phone: 3-1506.

AREA 4

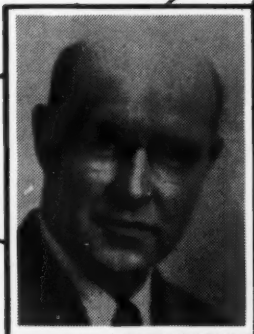
COUNTIES: Kent, Lake, Manistee, Mason, Mecosta, Muskegon, Newaygo, Oceana, Ottawa, Wexford, Benzie, Grand Traverse, Leelanau, half of Ionia, half of Montcalm, half of Osceola.
(NOTE: The area indicated by the dotted line is covered periodically. Because this is a sparsely populated area, a full-time field man is not assigned to the section, but it is serviced by the Area 4 representative).

POPULATION	731,630
DOCTORS IN AREA	755
BLUE SHIELD PAYMENTS TO DOCTORS (1951)	\$1,369,234
BLUE CROSS HOSPITALS	25

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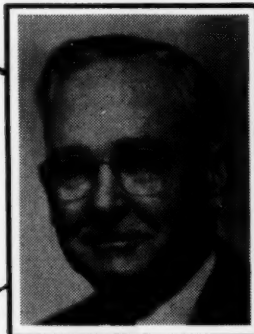
THESE ARE THE PEOPLE



R. S. BREAKEY, M.D.
Member
MSMS—Liaison Committee



JOHN WELLMAN, M.D.
Member
MSMS—Liaison Committee



ROBERT MORSE
Representative
MMS—Professional Relations

Referred to as the "dean of Professional Relations" **BOB MORSE** has had a long career in field work with Michigan Medical Service.

Bob joined Blue Shield in 1943 as one of the first field men to work outside of Wayne County. He has had his territory continuously ever since.

His tenacity in tracking down an unpaid bill is almost uncanny and certainly appreciated by the doctors in his area. Those who know Bob know that if they ask him a Blue Shield question he gets them the answer . . . and quickly! Doctors in his area know him as "old reliable" and "Mr. Blue Shield himself".

Before beginning Blue Shield work Bob was employed as Agency Director in the State Insurance Department. He was elevated to Deputy Insurance Commissioner in 1936, and not long after, began work with the D. F. Broderick Company as Agency Manager for their fire business.

Known as an authority of fresh water fishing, Bob boasts of knowing where the big ones can be caught even when they're not biting any place else. Along with his fishing he enjoys stamp collecting. A more jovial and lovable personality would be impossible to find. He is married and his two children are the light of his life.

Office: 458 Hollister Building, Lansing, Phone: 2-1364.

Home: 216 W. St. Joseph, Lansing, Phone: 2-9439.

AREA 5

COUNTIES: Bay, Clinton, Eaton, Genesee, Gratiot, Ingham, Isabella, Livingston, Midland, Saginaw, Shiawassee, Gladwin, Antrim, Charlevoix, Clare, Emmett, Kalkaska, Missaukee, half of Ionia, half of Montcalm, half of Osceola.

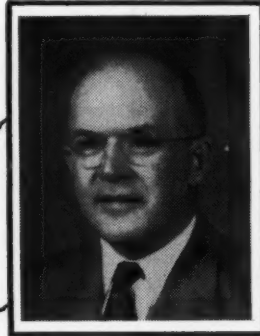
(NOTE: The area indicated by the dotted line is covered periodically. Because this is a sparsely populated area, a full-time field man is not assigned to the section, but it is serviced by the Area 5 representative).

POPULATION	1,000,334
DOCTORS IN AREA	983
BLUE SHIELD PAYMENTS TO DOCTORS (1951)	\$3,366,473
BLUE CROSS HOSPITALS	36

THESE ARE THE PEOPLE



ANTON PATTI
Representative
MMS—Professional Relations



D. B. WILEY, M.D.
Member
MSMS—Liaison Committee

ANTON "Tony" PATTI is the newest addition to the Professional Relations Department. He began his work with Blue Shield in March of this year and is only now beginning to become acquainted with his area.

Tony is a likable guy from the beginning. Quiet, reserved, yet aggressive when the occasion presents itself, he is the kind of individual who has the polish and graciousness it takes to make a good field man.

He begins his work with Blue Shield after a lifetime of music. He played with the Detroit Symphony Orchestra for six consecutive seasons occupying a chair in the viola section. For the two years immediately preceding his work with Professional Relations, he led the Sheraton-Cadillac Hotel orchestra.

Tony spent five years with the Army. He was a First Lieutenant in the Infantry with the Fifth Corps Headquarters in Europe.

His education includes a year and a half in the Detroit Institute of Technology.

He is married, has three children and enjoys golf, fishing and music.

Office: 1200 Washington Boulevard Building, 234 State Street, Detroit, Phone: WO. 5-2700.

Home: 226 Prospect, Romeo, Phone: 3202.

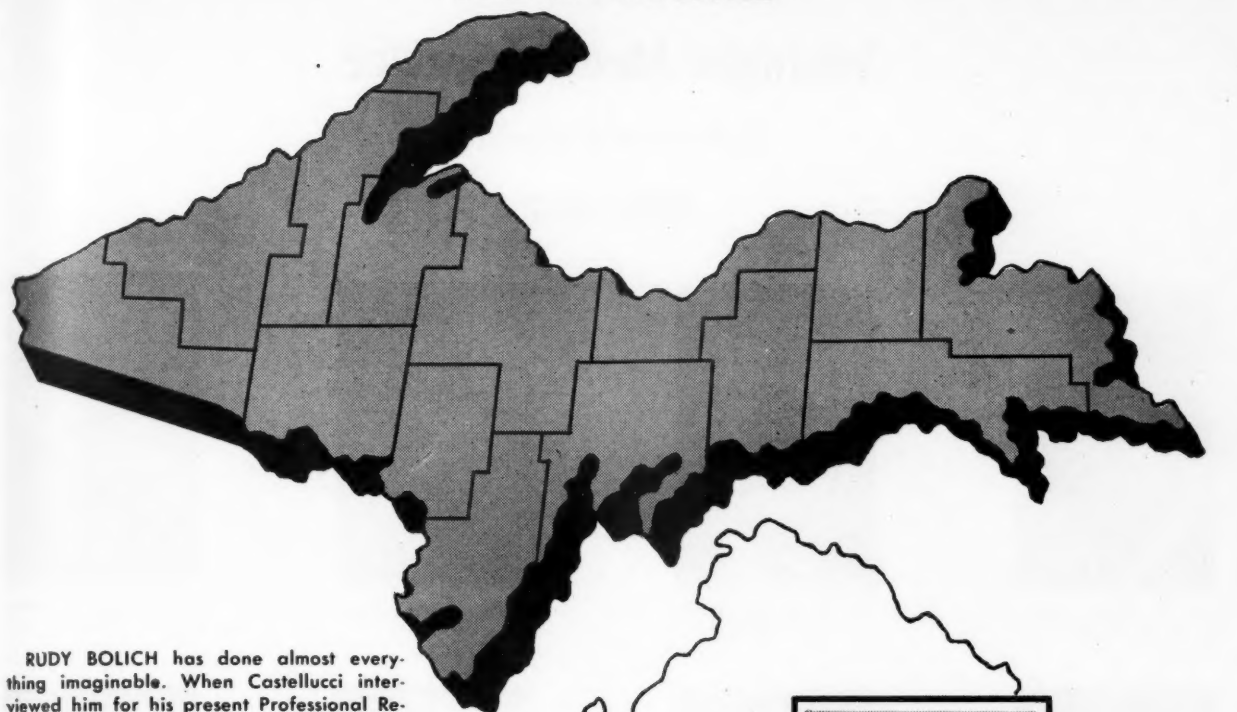
AREA 6

COUNTIES: Huron, Lapeer, Macomb, Oakland, St. Clair, Sanilac, Tuscola, Alcona, Alpena, Arenac, Cheboygan, Crawford, Iosco, Montmorency, Ogemaw, Oscoda, Otsego, Presque Isle, Roscommon.

(NOTE: The area indicated by the dotted line is covered periodically. Because this is a sparsely populated area, a full-time field man is not assigned to the section, but it is serviced by the Area 6 representative).

POPULATION	918,027
DOCTORS IN AREA	638
BLUE SHIELD PAYMENTS TO DOCTORS (1951)	\$1,861,650
BLUE CROSS HOSPITALS	20

THESE ARE THE PEOPLE



RUDY BOLICH has done almost everything imaginable. When Castellucci interviewed him for his present Professional Relations job he asked him about his previous working experience. After many minutes of talking and explaining the various jobs he has had, John finally said, "You've done a lot of things, and the only thing I can think of that you haven't been is an old man!" And this is just about the only occupation Rudy has to look forward to.

He entered the Ferris Institute in 1931 in the curriculum prescribed for premedical students. He left the Institute a year later and began studying Cosmotology at the Jarvis Academy in Minneapolis. Two years later, he entered the Woodward Business College in Ironwood.

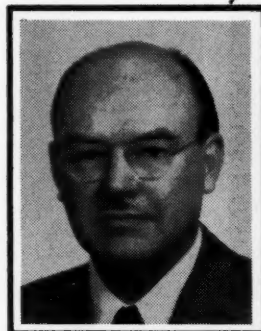
Throughout his life Rudy has been interested in Music. He is an accomplished musician, has had his own orchestras and has played with some of the finest popular bands of the country.

After a four year stint with the Army Medical Corps., the Army Band and Orchestra, Rudy returned to Michigan as the assistant administrator of Gladwin Hospital in Ironwood. His work with Blue Shield began in 1949.

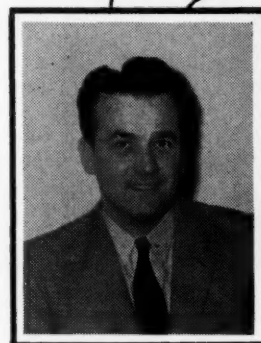
He is married and has two children—a daughter and son. His present interests are photography, radio, and electronics. Incidentally, Rudy covers the largest Professional Relations territory in the state.

Office: 11 Union National Bank Building, 101 W. Washington Street, Marquette, Phone: 2948.

Home: 244 E. Ridge Street, Ironwood, Phone: 2194.



W. H. HURON, M.D.
Member
MSMS—Liaison Committee



RUDOLPH BOLICH
Representative
MMS—Professional Relations

AREA 7

Upper Peninsula

POPULATION	302,258
DOCTORS IN AREA	227
BLUE SHIELD PAYMENTS TO DOCTORS (1951).....	\$372,397
BLUE CROSS HOSPITALS	18

Michigan Medical Service

Officers and Directors

1951-1952



R. L. Novy, M.D.
President



W. HAUGHEY, M.D.
Vice President



R. H. BAKER, M.D.
Secretary



WALDO I. STODDARD
Treasurer



K. BABCOCK, M.D.



E. D. BARNETT, M.D.



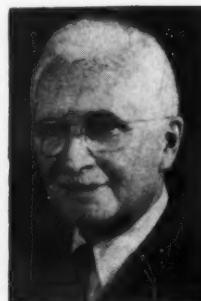
E. C. BAUMGARTEN
M.D.



HARRY BECKER



WILLIAM BROMME,
M.D.



E. I. CARR, M.D.



B. D. DANN



J. S. DETAR, M.D.



L. F. FOSTER, M.D.

Michigan Medical Service

Directors

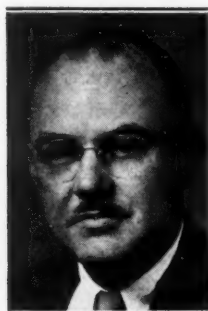
1951-1952



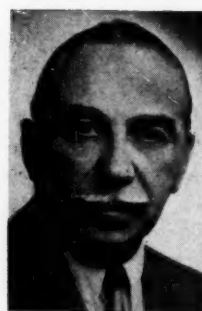
CARLETON FOX, D.D.S.



C. K. HASLEY, M.D.



W. H. HURON, M.D.



W. A. HYLAND, M.D.



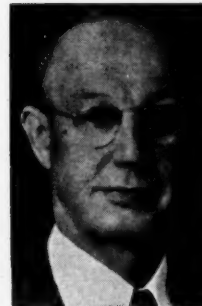
A. C. KERLIKOWSKE,
M.D.



RALPH N. LONG



W. C. PERDEU, D.D.



G. C. PENBERTHY,
M.D.



E. A. OAKES, M.D.



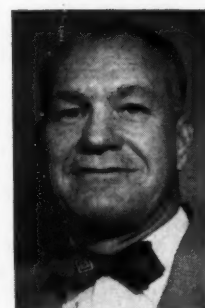
JOHN REID



PHILIP RILEY, M.D.



E. F. SLADEK, M.D.



ARCH WALLS, M.D.



RONALD YAW

Michigan State Medical Society

Past Presidents 1866-1951

- | | |
|---|---|
| 1866—*C. M. Stockwell, Port Huron | 1905—*David Inglis, Detroit |
| 1867—*J. H. Jerome, Saginaw | 1906—*Charles B. Stockwell, Port Huron |
| 1868—*Wm. H. DeCamp, Grand Rapids | 1907—*Hermon Ostrander, Kalamazoo |
| 1869—*Richard Inglis, Detroit | 1908—*A. F. Lawbaugh, Calumet |
| 1870—*I. H. Bartholomew, Lansing | 1909—*J. H. Carstens, Detroit |
| 1871—*H. O. Hitchcock, Kalamazoo | 1910—*C. B. Burr, Flint |
| 1872—*Alonzo B. Palmer, Ann Arbor | 1911—*D. Emmett Welsh, Grand Rapids |
| 1873—*E. W. Jenk, Detroit | 1912—*Wm. H. Sawyer, Hillsdale |
| 1874—*R. C. Kedzie, Lansing | 1913—*Guy L. Kiefer, Detroit |
| 1875—*Wm. Brodie, Detroit | 1914—*Reuben Peterson, Ann Arbor |
| 1876—*Abram Sager, Ann Arbor | 1915—*A. W. Hornbogen, Marquette |
| 1877—*Foster Pratt, Kalamazoo | 1916—*Andrew P. Biddle, Detroit |
| 1878—*Ed. Cox, Battle Creek | 1917—*Andrew P. Biddle, Detroit |
| 1879—*George K. Johnson, Grand Rapids | 1918—Arthur M. Hume, Owosso |
| 1880—*J. R. Thomas, Bay City | 1919—*Charles H. Baker, Bay City |
| 1881—*J. H. Jerome, Saginaw | 1920—*Angus McLean, Detroit |
| 1882—*Geo. W. Topping, DeWitt | 1921—*Wm. J. Kay, Lapeer |
| 1883—*A. F. Whelan, Hillsdale | 1922—*W. T. Dodge, Big Rapids |
| 1884—*Donald Maclean, Detroit | 1923—*Guy L. Connor, Detroit |
| 1885—*E. P. Christian, Wyandotte | 1924—*C. C. Clancy, Port Huron |
| 1886—*Charles Shepard, Grand Rapids | 1925—*Cyrenus G. Darling, Ann Arbor |
| 1887—*T. A. McGraw, Detroit | 1926—*J. B. Jackson, Kalamazoo |
| 1888—*S. S. French, Battle Creek | 1927—*Herbert E. Randall, Flint |
| 1889—*G. E. Frothingham, Detroit | 1928—Louis J. Hirschman, Detroit |
| 1890—*L. W. Bliss, Saginaw | 1929—J. D. Brook, Grandville |
| 1891—*George E. Ranney, Lansing | 1930—*Ray C. Stone, Battle Creek |
| 1892—*Charles J. Lundy
(Died before taking office) | 1931—*Carl F. Moll, Flint |
| *Gilbert V. Chamberlain, Flint, Act-
ing President | 1932—J. Milton Robb, Detroit |
| 1893—*Eugene Boise, Grand Rapids | 1933—*George LeFevre, Muskegon |
| 1894—*Henry O. Walker, Detroit | 1934—*R. R. Smith, Grand Rapids |
| 1895—*Victor C. Vaughan, Ann Arbor | 1935—Grover C. Penberthy, Detroit |
| 1896—*Hugh McColl, Lapeer | 1936—Henry E. Perry, Newberry |
| 1897—*Joseph B. Griswold, Grand Rapids | 1937—Henry Cook, Flint |
| 1898—*Ernest L. Shurly, Detroit | 1938—Henry A. Luce, Detroit |
| 1899—*A. W. Alvord, Battle Creek | 1939—Burton R. Corbus, Grand Rapids |
| 1900—*P. D. Patterson, Charlotte | 1940—Paul R. Urmston, Bay City |
| 1901—*Leartus Connor, Detroit | 1941—Henry R. Carstens, Detroit |
| 1902—*A. E. Bulson, Jackson | 1942—H. H. Cummings, Ann Arbor |
| 1903—*Wm. F. Breakey, Ann Arbor | 1943—C. R. Keyport, Grayling |
| 1904—*B. D. Harison, Sault Ste. Marie | 1944—*A. S. Brunk, Detroit |
| *Deceased. | 1945—*V. M. Moore, Grand Rapids
(Died before taking office) |
| | 1945—R. S. Morrish, Flint |
| | 1946—Wm. A. Hyland, Grand Rapids |
| | 1947—*P. L. Ledwidge, Detroit |
| | 1948—E. F. Sladek, Traverse City |
| | 1949—Wilfrid Haughey, Battle Creek
(President-for-a-Day, Sept. 21, 1949) |
| | 1949—W. E. Barstow, St. Louis |
| | 1950—C. E. Umphrey, Detroit |
| | 1951—Otto O. Beck, Birmingham |

Michigan State Medical Society

The 87th Annual Session



WILLIAM BROMME, M.D.
Detroit
Council Chairman



OTTO O. BECK, M.D.
Birmingham
President



R. H. BAKER, M.D.
Pontiac
Speaker



L. FERNALD FOSTER, M.D.
Bay City
Secretary

OFFICIAL CALL

The Michigan State Medical Society will convene in Annual Session in Detroit, Michigan, on September 22, 23, 24, 25, 26, 1952. The provisions of the Constitution and By-Laws and the Official Program will govern the deliberations.

OTTO O. BECK, M.D.
President

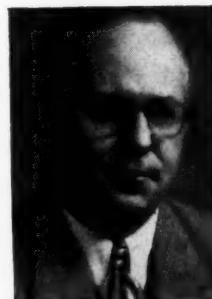
WILLIAM BROMME, M.D.
Council Chairman

R. H. BAKER, M.D.
Speaker

J. E. LIVESAY, M.D.
Vice Speaker

Attest:

L. FERNALD FOSTER, M.D.
Secretary



J. E. LIVESAY, M.D.
Flint
Vice Speaker

TWO-DAY SESSION OF HOUSE OF DELEGATES

SEPTEMBER 22-23, 1952

The 1952 House of Delegates of the Michigan State Medical Society will hold a two-day session beginning Monday, September 22 at 10:00 a.m. The business of the House of Delegates will be transacted in the Grand Ballroom of the Sheraton-Cadillac Hotel, Detroit.

The House will also meet on Monday at 2:00 p.m. and at 8:00 p.m. and on Tuesday, September 23, at 10:00 a.m. and at 8:00 p.m.

The intervals between meetings of the House of

Delegates have been spaced to permit the Reference Committees ample time to transact all business referred to them.

Seating of Delegates

"Any Delegate-Elect not present to be seated at the hour of call of the first meeting may be replaced by the accredited Alternate next on the list as certified by the Secretary of the component County Society involved."—MSMS By-Laws, Chapter 8, Section 6.

TENTATIVE OUTLINE OF 1952 ASSEMBLY AND SECTION SPEAKERS **87TH ANNUAL SESSION, MICHIGAN STATE MEDICAL SOCIETY**

Detroit, September, 1952

Time	Wednesday September 24, 1952	Thursday September 25, 1952	Friday September 26, 1952
A.M. 8:30-9:00	Registration Exhibits open	Registration Exhibits open	Registration Exhibits open
9:00-9:30	<i>Surgery</i> CLAUDE S. BECK, M.D. Cleveland, Ohio	<i>Gynecology</i> EMIL NOVAK, M.D. Baltimore, Maryland	<i>Medicine</i> DWIGHT E. HARKEN, M.D. Boston, Mass.
9:30-10:00	<i>Medicine</i> DAVID A. RYTAND, M.D. San Francisco, Calif.	<i>Otolaryngology</i> BEN H. SENTURIA, M.D. St. Louis, Mo.	<i>Syphilology</i> EVAN W. THOMAS, M.D. Albany, N. Y.
10:00-11:00	Intermission to View Exhibits	Intermission to View Exhibits	Intermission to View Exhibits
11:00-11:30	<i>Pediatrics</i> MILTON I. LEVINE, M.D. New York, New York	<i>Anesthesia</i> JOHN J. BONICA, M.D. Tacoma, Washington	<i>General Practice</i> PHILIP THOREK, M.D. Chicago, Ill.
11:30-12:00 M	<i>Dermatology</i> LEONARD F. WEBER, M.D. Chicago, Ill.	<i>Public Health & Preventive Medicine</i> GAYLORD W. ANDERSON, M.D. Minneapolis, Minnesota	<i>Nervous & Mental Diseases</i> ROLAND P. MACKAY, M.D. Chicago, Ill.
P.M. 12:00-1:00	Discussion Conference	Discussion Conference	Discussion Conference
2:00-2:30	<i>Urology</i> ORMOND S. CULP, M.D. Rochester, Minn.	<i>Gastroenterology & Proctology</i> SAMUEL F. MARSHALL, M.D. Boston, Mass.	<i>Pediatrics</i> DANIEL C. DARROW, M.D. New Haven, Conn.
2:30-3:00	<i>Obstetrics</i> DUNCAN E. REID, M.D. Boston, Mass.	<i>General Practice</i> GEORGE CRILE, JR., M.D. Cleveland, Ohio	<i>Radiology</i> EARL R. MILLER, M.D. San Francisco, Calif.
3:00-4:00	Intermission to View Exhibits	Intermission to View Exhibits	3:00 to 3:30 P.M. Final Intermission to View Exhibits
4:00-4:30	<i>Ophthalmology</i> PETER C. KRONFELD, M.D. Chicago, Ill.	<i>Obstetrics</i> EDWIN J. DeCOSTA, M.D. Chicago, Ill.	<i>Surgery</i> 3:30-4:00 CLAUDE E. WELCH, M.D. Boston, Mass.
4:30-5:00	<i>Surgery</i> Speaker to be announced	<i>Surgery</i> Speaker to be announced	<i>Medicine</i> 4:00 to 4:30 P.M. GARFIELD G. DUNCAN, M.D. Philadelphia, Pa.
5:00-6:00	Five Section Meetings 5:00 to 6:00 P.M. <i>Dermatology-Syphilology</i> LEONARD F. WEBER, M.D. Chicago, Ill. <i>Pediatrics</i> MILTON I. LEVINE, M.D. New York, New York <i>Urology</i> ORMOND S. CULP, M.D. Rochester, Minn. <i>Obstetrics-Gynecology</i> DUNCAN E. REID, M.D. Boston, Mass. <i>Ophthalmology</i> PETER C. KRONFELD, M.D. Chicago, Ill.	Five Section Meetings 5:00 to 6:00 P.M. <i>Anesthesia</i> JOHN J. BONICA, M.D. Tacoma, Washington <i>Otolaryngology</i> BEN H. SENTURIA, M.D. St. Louis, Mo. <i>Public Health & Preventive Medicine</i> GAYLORD W. ANDERSON, M.D. Minneapolis, Minn. <i>Gastroenterology & Proctology</i> SAMUEL F. MARSHALL, M.D. Boston, Mass. <i>Surgery</i> Speaker to be announced	Four Section Meetings 4:30 to 5:30 P.M. <i>Radiology</i> EARL R. MILLER, M.D. San Francisco, Calif. <i>Medicine</i> DWIGHT E. HARKEN, M.D. Boston, Mass. <i>General Practice</i> PHILIP THOREK, M.D. Chicago, Ill. <i>Nervous & Mental Diseases</i> ROLAND P. MACKAY, M.D. Chicago, Illinois
8:30	8:30 A.M. to 10:30 P.M. Officers' Night Biddle Lecture PAUL DE KRUIF, Ph.D. Holland, Michigan	10:00 P.M. to 1:00 A.M. State Society Night MSMS Entertainment	5:30 P.M. END OF ASSEMBLY

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Michigan State Medical Society

The 87th Annual Session

SHERATON-CADILLAC HOTEL, DETROIT, MICHIGAN

September 22, 23, 24, 25, 26, 1952

INFORMATION

- **DETROIT WILL BE HOST TO MSMS IN SEPTEMBER, 1952.**
- **MSMS HOUSE OF DELEGATES** convenes Monday, September 22 at 10:00 a.m., English Room, Sheraton-Cadillac Hotel. It will hold three meetings on Monday and two meetings on Tuesday, September 23.
- **THE PROGRAM OF THE ASSEMBLY** for the 87th Annual Session of the Michigan State Medical Society lists guest speakers from all parts of the United States. They are the usual stars in the medical world which always grace the annual conventions of the Michigan State Medical Society; they insure a valuable concentrated continuation course in all phases of medicine and surgery for the busy practitioners of Michigan, neighboring States and the Province of Ontario, on September 24-25-26, 1952.
- **REGISTRATION**, Tuesday afternoon through Friday afternoon, September 23-26, Fifth Floor, Sheraton-Cadillac Hotel. Advance registration—on Tuesday and early Wednesday morning—will save your time. Present your State Medical Society or Canadian Medical Association membership card to expedite registration.
- **NO REGISTRATION FEE FOR STATE MEDICAL SOCIETY AND CMA MEMBERS.**

Doctors of Medicine, who are not members of their state medical society or of the Canadian Medical Association, will be accorded the privileges of the MSMS Annual Session upon payment of a \$25.00 registration fee.
- **REGISTER AS SOON AS YOU ARRIVE. ADMISSION BY BADGE ONLY.**
- **ALL SUBJECTS** at the MSMS Annual Session are applicable to clinical medicine. They stress diagnosis and treatment, usable in everyday practice.
- **POSTGRADUATE CREDITS** given to every MSMS member who attends MSMS Annual Session.
- **SIX ASSEMBLIES AND ONE PUBLIC MEETING**—fourteen Section Meetings—three Discussion Conferences on September 24-25-26.
- **A DISCUSSION CONFERENCE**—featuring the eight Guest Essayists of each day—will be held daily from 12:00 noon to 1:00 p.m. in the Grand Ballroom of the Sheraton-Cadillac Hotel. Audience participation desired.
- **SECTION MEETINGS** will follow the daily Assemblies—5:00 to 6:00 p.m. on Wednesday-Thursday, and 4:30 to 5:30 p.m. on Friday.
- **PAPERS WILL BEGIN AND END ON TIME.** This scientific meeting will feature by-the-clock promptness and regularity.
- **NINETY-NINE TECHNICAL EXHIBITS** will contain much of interest and value. Intermissions to view the exhibits have been arranged.
- **ARCH WALLS, M.D., DETROIT**, is General Chairman of the Detroit Committee on Arrangements for the 1952 MSMS Annual Session.
- **CABARET-STYLE DANCE AND ENTERTAINMENT**, with the compliments of the Michigan State Medical Society, will be held in the Grand Ballroom, Sheraton-Cadillac Hotel, Thursday evening, September 25. All who register, and their ladies, will receive a card of admission and are cordially invited to attend.
- **THE WOMAN'S AUXILIARY** to the Michigan State Medical Society will present an attractive social and business program at the Statler Hotel, Detroit. The wife of every MSMS member is cordially invited to attend.
- **MEMBERS OF MICHIGAN MEDICAL SERVICE** will meet in annual Session, Tuesday, September 24, Grand Ballroom, Sheraton-Cadillac Hotel, at 2:00 p.m., following the annual MMS luncheon at 1:00 p.m. in the English Room.

SCIENTIFIC ASSEMBLY

Wednesday-Thursday-Friday, Sept. 24-25-26, 1952

SAVE AN ORDER FOR THE EXHIBITOR AT THE MICHIGAN STATE MEDICAL SOCIETY ANNUAL SESSION

MICHIGAN STATE MEDICAL SOCIETY

The 87th Annual Session

Sheraton-Cadillac Hotel, Detroit, September 22-23, 1952

House of Delegates

ORDER OF BUSINESS*

MONDAY, SEPTEMBER 22

English Room, Sheraton-Cadillac Hotel, Detroit

10:00 a.m.—First Meeting

1. Call to order by Speaker
2. Report of Committee on Credentials
3. Roll call
4. Appointment of Reference Committees
 - (a) On Officers' Reports
 - (b) On Reports of The Council
 - (c) On Reports of Standing Committees
 - (d) On Reports of Special Committees
 - (e) On Constitution and By-Laws
 - (f) On Resolutions
 - (g) On Special Memberships
 - (h) On Rules and Order of Business
 - (i) On Legislation and Public Relations
 - (j) On Hygiene and Public Health
 - (k) On Medical Service and Prepayment Insurance
 - (l) On Miscellaneous Business
 - (m) On Executive Session
 - (n) On Emergency Medical Service
5. Speaker's Address—R. H. Baker, M.D., Pontiac
6. President's Address—Otto O. Beck, M.D., Birmingham
7. President-Elect's Address—R. J. Hubbell, M.D., Kalamazoo
8. Annual and Supplemental Reports of The Council—William Bromme, M.D., Detroit, Chairman
9. Report of Delegates to American Medical Association—W. D. Barrett, M.D., Detroit, Chairman
10. Brief of Annual Report of Woman's Auxiliary President—Mrs. R. S. Breakey, Lansing
11. Selection of Michigan's Foremost Family Physician
12. Resolutions**

MONDAY, SEPTEMBER 22

English Room, Sheraton-Cadillac Hotel, Detroit

2:00 p.m.—Second Meeting

13. Supplementary Report of Committee on Credentials
14. Roll Call
15. Reports of MSMS Standing Committees
 - A. Committee on Postgraduate Medical Education
 - B. Preventive Medicine Committee
 - (1) Rheumatic Fever Control Committee (and Subcommittees)
 - (2) Cancer Control Committee (and Subcommittees)
 - (3) Maternal Health Committee

*See the Constitution, Articles IV, VII and XII, and the By-laws, Chapter 8 on "House of Delegates."

**All Resolutions, special reports, and new business shall be presented in writing in triplicate (By-laws, Chapter 8, Section 10-m).

- (4) Venereal Disease Control Committee
- (5) Tuberculosis Control Committee
- (6) Industrial Health Committee
- (7) Mental Hygiene Committee
- (8) Child Welfare Committee
 - (a) Subcommittee on Hearing Defects
 - (b) Subcommittee of Ophthalmologists
- (9) Iodized Salt Committee
- (10) Geriatrics Committee
 - (a) Subcommittee on Diabetes Control
 - (b) Subcommittee to Study Problem of Caring for Aged
- (11) Committee on Infectious Diarrhea
- C. Committee on Distribution of Medical Care
- D. Committee on Public Relations (and Subcommittees)
- E. Committee on Ethics
- F. Legislative Committee

16. Reports of Special Committees

- A. Beaumont Memorial Restoration Committee
- B. Scientific Radio Committee
- C. Advisory Committee to Woman's Auxiliary
- D. Liaison Committee with Michigan State Medical Assistants Society
- E. Advisory Committee to National Foundation for Infantile Paralysis

Reports of the Committees of the Council, including Committee on Scientific Work, are included in the Annual Report of the Council

MONDAY, SEPTEMBER 22

Grand Ballroom, Sheraton-Cadillac Hotel, Detroit

8:00 p.m.—Third Meeting

17. Supplementary Report of Committee on Credentials
18. Roll Call
19. Unfinished Business
20. New Business
21. Reports of Reference Committees
 - (a) On Officers' Reports
 - (b) On Reports of The Council
 - (c) On Reports of Standing Committees
 - (d) On Reports of Special Committees
 - (e) On Constitution and By-Laws
 - (f) On Resolutions
 - (g) On Special Memberships
 - (h) On Rules and Order of Business
 - (i) On Legislation and Public Relations
 - (j) On Hygiene and Public Health
 - (k) On Medical Service and Prepayment Insurance
 - (l) On Miscellaneous Business
 - (m) On Executive Session
 - (n) On Emergency Medical Service

ORDER OF BUSINESS

TUESDAY, SEPTEMBER 23

Grand Ballroom, Sheraton-Cadillac Hotel, Detroit

- 10:00 a.m.—Fourth Meeting
22. Supplementary Report of Committee on Credentials
23. Roll Call
24. Unfinished Business
25. New Business
26. Supplementary Reports of Reference Committees

TUESDAY, SEPTEMBER 23

Grand Ballroom, Sheraton-Cadillac Hotel, Detroit

8:00 p.m.—Fifth Meeting

27. **Supplementary Report of Committee on Credentials**
28. **Roll Call**
29. **Special Order of Business**
30. **Unfinished Business**
31. **Supplemental Report of The Council**
32. **Supplementary Reports of Reference Committees**
33. **Elections**

- (a) **Councillors:**
7th District—H. B. Zemmer, M.D., Lapeer—Incumbent
8th District—L. C. Harvie, M.D., Saginaw—Incumbent
9th District—G. B. Saltonstall, M.D., Charlevoix—Incumbent
10th District—F. H. Drummond, M.D., Kawkawlin—Incumbent
- (b) **Delegates to American Medical Association:**
W. D. Barrett, M.D., Detroit—Incumbent
W. H. Huron, M.D., Iron Mountain—Incumbent
R. L. Novy, M.D., Detroit—Incumbent
- (c) **Alternate Delegates to the American Medical Association:**
R. H. Denham, M.D., Grand Rapids—Incumbent
C. I. Owen, M.D., Detroit—Incumbent
- (d) **President-Elect**
- (e) **Speaker of House of Delegates**
- (f) **Vice Speaker of House of Delegates**
- 34. Adjournment.**

Doctor:

Are you and

your family

registered to

vote in November?

This is a Must!

Annual Session Appointments

- General Chairman of the 1952 MSMS Annual Session is Arch Walls, M.D., Detroit.
- *House of Delegates Press Relations Committee:*
 - R. A. Johnson, M.D., Detroit, *Chairman*
 - R. H. Baker, M.D., Pontiac
 - H. F. Dibble, M.D., Detroit
 - L. Fernald Foster, M.D., Bay City
 - J. E. Livesay, M.D., Flint
- *Scientific Assembly Press Relations Committee:*
 - R. A. Johnson, M.D., Detroit, *Chairman*
 - E. C. Long, M.D., Detroit
 - W. S. Reveno, M.D., Detroit
 - A. E. Schiller, M.D., Detroit
 - C. L. Weston, M.D., Owosso

HOTEL RESERVATIONS

MICHIGAN STATE MEDICAL SOCIETY

87th Annual Session

Detroit, September 22 to 26, 1952

The reservation blank below is for your convenience in making your hotel reservations in Detroit. Please send your application to Robert M. Buckley, Sheraton-Cadillac Hotel, Detroit, Michigan. Mailing your application now will be of material assistance in securing hotel accommodations.

As very few singles are available, registrants are requested to co-operate with the Committee on Hotels by sharing a room with another registrant, when convenient.

Committee on Hotels,
Michigan State Medical Society
c/o Sheraton-Cadillac Hotel,
Detroit, Michigan

Attention: Robert M. Buckley

Please make hotel reservation (s) as indicated below:

.....Single Room(s)

.....Double Room(s) for.....persons

.....Twin-Bedded Room(s) for.....persons

Arriving September.....hourA.M.P.M.

Leaving September.....hourA.M.P.M.

Hotel of First Choice:

Second Choice:.....

Names and addresses of all applicants including person making reservation:

Name	Address	City	State
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Date Signature.....

Address City.....

MSMS HOUSE OF DELEGATES—1952

Delegates and Alternates

(Names of Alternates appear in *Italics*)

ALLEGAN

Lewis F. Brown, M.D., 133 E. Allegan Street, Otsego
Elwin B. Johnson, M.D., 144 Brady, Allegan

ALPENA-ALCONA-PRESQUE ISLE

Elbert S. Parmenter, M.D., 140 E. Washington, Alpena
James E. Spens, M.D., Professional Building, Alpena

BARRY

Alexander B. Gwinn, M.D., City Bank Building,
Hastings
*Herbert S. Wedel, M.D., 304 S. Washington Street,
Hastings*

BAY-ARENAC-IOSCO

Orlen J. Johnson, M.D., 207 N. Walnut, Bay City
Walter S. Stinson, M.D., 101 W. John, Bay City
*Robert E. Fisher, M.D., 5th and Jackson Streets,
Bay City*
Neal R. Moore, M.D., 704 N. Jackson, Bay City

BERRIEN

Donald W. Thorup, M.D., 610 Fidelity Building,
Benton Harbor
Franklyn A. Rice, M.D., 318 N. Fourth, Niles
Henry J. Klos, M.D., Mercy Hospital, Benton Harbor
*Frederick H. Lindensfeld, M.D., 8 N. St. Joseph Ave-
nue, Niles*

BRANCH

Harold J. Meier, M.D., 87 W. Pearl, Coldwater
Nathaniel J. Walton, M.D., 61 E. Chicago, Quincy

CALHOUN

Stanley T. Lowe, M.D., 1009 Security Bank Building,
Battle Creek
Harvey C. Hansen, M.D., 417 Post Building, Battle
Creek
*James W. Hubly, M.D., 1407 Security Bank Bldg.,
Battle Creek*
*Leland R. Keagle, M.D., 196 North Avenue, Battle
Creek*

CASS

Sherman L. Loupee, M.D., Dowagiac
Uriah M. Adams, M.D., Marcellus

CHIPPEWA-MACKINAC

Benjamin T. Montgomery, M.D., 309 Ashmun, Sault
Ste. Marie
*Donnell C. Howe, M.D., 300 Court Street, Sault Ste.
Marie*

CLINTON

Franklin W. Smith, M.D., Ovid
William B. McWilliams, M.D., Maple Rapids

DELTA-SCHOOLCRAFT

William A. LeMire, M.D., 1106 First Avenue S.,
Escanaba
Albert H. Miller, M.D., 904 Wisconsin, Gladstone

DICKINSON-IRON

Lionel E. Irvine, M.D., 422 Third Street, Iron River
*William Fiedling, M.D., First National Bank Building,
Norway*

EATON

To be announced

GENESEE

Clifford W. Colwell, M.D., 706 Citizens Bank Building,
Flint
Leon M. Bogart, M.D., 1008 Genesee Bank Building,
Flint
Jackson E. Livesay, M.D., 619 Mott Foundation
Building, Flint
Frank D. Johnson, M.D., 312 Paterson Building, Flint
*Harold H. Hiscock, M.D., 1315 Mott Foundation
Building, Flint*
*Edwin P. Vary, M.D., 608 First National Building,
Flint*
Franklin W. Baske, M.D., 923 Maxine Street, Flint
*Fleming A. Barbour, M.D., 1439 Mott Foundation
Building, Flint*

GOGEBIC

Wayne A. Gingrich, M.D., 109 E. Aurora Street,
Ironwood
*Florian J. Santini, M.D., 109 E. Aurora Street,
Ironwood*

GRAND TRAVERSE-LEELANAU-BENZIE

Donald G. Pike, M.D., 876 E. Front Street, Traverse
City
*Charles E. Lemen, M.D., 216½ E. Front Street, Trav-
erse City*

GRATIOT-ISABELLA-CLARE

Myron G. Becker, M.D., Edmore
Earle S. Oldham, M.D., Breckenridge

HILLSDALE

Arthur W. Strom, M.D., 32 S. Broad Street, Hillsdale
Luther W. Day, M.D., 111 Evans Street, Jonesville

HOUGHTON-BARAGA-KEWEENAW

John T. P. Wickliffe, M.D., 1167 Calumet Avenue,
Calumet
Paul S. Sloan, M.D., 214 Clark, Houghton

HURON

Charles W. Oakes, Jr., M.D., Harbor Beach
Charles I. Herrington, M.D., Bad Axe

INGHAM

Franklin L. Troost, M.D., 4341 W. Delhi Road, Holt
Harold W. Wiley, M.D., 137 N. Larch Street, Lansing
Kenneth H. Johnson, M.D., 1116 Olds Tower, Lansing
Oliver B. McGillicuddy, M.D., 1816 Olds Tower,
Lansing
John M. Wellman, M.D., 301 Seymour, Lansing
Edmund J. Robson, M.D., 215 N. Walnut, Lansing
Leo W. Walker, M.D., St. Lawrence Hospital, Lansing
*Lawrence A. Drolett, M.D., 903 Prudden Building,
Lansing*

IONIA-MONTCALM

William L. Bird, M.D., Greenville
Milton E. Slagh, M.D., Saranac

JACKSON

John D. Van Schoick, M.D., Hanover
John W. Rice, M.D., 603 Jackson City Bank, Jackson
Nathan D. Munro, 740 W. Michigan, Jackson
*James J. O'Meara, M.D., 1508 Reynolds Building,
Jackson*

MSMS HOUSE OF DELEGATES—1952

KALAMAZOO

Frederick C. Ryan, M.D., 507 S. Burdick, Kalamazoo
 Irmel W. Brown, M.D., 306 Kalamazoo National
 Bank Building, Kalamazoo
 William A. Scott, M.D., 208 Bronson Medical Center,
 Kalamazoo
 Kenneth L. Crawford, M.D., 612 Douglas Avenue,
 Kalamazoo
 Warren B. Crane, M.D., 420 S. Rose, Kalamazoo
 Paul F. Cooper, M.D., 252 E. Lovell Street, Kalamazoo

KENT

Andrew A. Van Solkema, M.D., 953 E. Fulton Street,
 Grand Rapids
 Luther C. Carpenter, Jr., M.D., 604 Metz Building,
 Grand Rapids
 Guy W. DeBoer, M.D., 220 Medical Arts Building,
 Grand Rapids
 William R. Torgerson, M.D., 321 Metz Building,
 Grand Rapids
 Torrance Reed, M.D., 304 Ashton Building, Grand
 Rapids
 Stanley L. Moleski, M.D., 528 Medical Arts Building,
 Grand Rapids
 Lee O. J. Grant, M.D., 420 Medical Arts Building,
 Grand Rapids
 Raymond S. Van Bree, M.D., 204 Loraine Building,
 Grand Rapids
 Charles E. Farber, M.D., 68 Ransom, NE, Grand
 Rapids

LAPEER

Daniel J. O'Brien, M.D., Nepassing Street, Lapeer
 James R. Doty, M.D., Clay Street, Lapeer

LENAWEE

John D. Hamilton, M.D., 122 Toledo Street, Adrian

LIVINGSTON

Harold C. Hill, M.D., 116 N. Michigan, Howell
 Thomas A. Barton, M.D., 112 E. Grand River, Howell

LUCE

Earl H. Campbell, M.D., Newberry
 Thomas W. Thompson, M.D., Newberry State Hospi-
 tal, Newberry

MACOMB

Sydney Scher, M.D., 610 Monitor-Leader Building,
 Mt. Clemens
 Russell W. Ullrich, M.D., 91 Cass Avenue, Mt.
 Clemens

MANISTEE

Ellery A. Oakes, M.D., 401 River Street, Manistee
 Robert E. Rowe, M.D., 326 18th Street, Manistee

MARQUETTE-ALGER

Lloyd W. Howe, M.D., Savings Bank Building, Mar-
 quette
 Robert F. Berry, M.D., Bacon Building, Marquette

MASON

Ephraim B. Boldyreff, M.D., Custer
 Arthur F. Boon, M.D., 808 W. Court Street, Lud-
 ington

MECOSTA-OSCEOLA-LAKE

Paul Ivkovich, M.D., Reed City
 Gordon H. Teo, M.D., 126 Maple Street, Big Rapids

MEDICAL SOCIETY OF NORTH CENTRAL COUNTIES

Stanley A. Stealy, M.D., P.O. Box 485, Grayling
 Louis F. Hayes, M.D., Grayling

MENOMINEE

John R. Heidenreich, M.D., Daggett
 Herman R. Brukardt, M.D., Electric Square Building,
 Menominee

MIDLAND

Harold L. Gordon, M.D., Dow Chemical Company,
 Midland
 Harold H. Gay, M.D., Dow Chemical Company,
 Midland

MONROE

Thomas A. McDonald, M.D., 7 E. Front, Monroe
 John P. Flanders, M.D., 31 Washington, Monroe

MUSKEGON

Robert D. Risk, M.D., 1160 Ransom Street, Muskegon
 Norbert W. Scholle, M.D., 1001 Peck Street, Mus-
 kegon Heights
 Devere R. Boyd, M.D., 1735 Peck Street, Muskegon
 Louis L. LeFevre, M.D., 450 W. Western Avenue,
 Muskegon

NEWAYGO

John P. Klein, M.D., 16 W. Sheridan, Fremont
 Brooker L. Masters, M.D., 38 State Street, Fremont

NORTHERN MICHIGAN MEDICAL SOCIETY

John R. Rodger, M.D., Bellaire
 Jerrian Van Dellen, M.D., East Jordan

OAKLAND

Palmer E. Sutton, M.D., 629 Washington Square
 Building, Royal Oak
 Harold A. Furlong, M.D., 932 Riker Building, Pontiac
 Oliver R. MacKenzie, M.D., 128 Common Street,
 Walled Lake
 James D. Green, M.D., 217 Briggs Building, 222 E.
 Maple, Birmingham

OCEANA

To be announced

ONTONAGON

William F. Strong, M.D., Ontonagon
 Carl R. Lahti, M.D., 700 River Street, Ontonagon

OTTAWA

Dirk C. Bloemendaal, M.D., 47 E. Main, Zeeland
 Kenneth N. Wells, M.D., Spring Lake

SAGINAW

Joseph P. Markey, M.D., 808 N. Michigan, Saginaw
 David P. Gage, M.D., 514 First Savings & Loan Build-
 ing, Saginaw
 Martin F. Bruton, M.D., 315 S. Jefferson, Saginaw
 Vital E. Cortopassi, M.D., 324 S. Washington Avenue,
 Saginaw
 Allen K. Cameron, M.D., 409 First Savings & Loan
 Building, Saginaw
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MSMS HOUSE OF DELEGATES—1952

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Michigan State Medical Society

HOUSE OF DELEGATES, 1952

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Annual Report

ANNUAL REPORT OF LEGISLATIVE COMMITTEE 1951-1952

The 1952 Legislature (second term of sixty-seventh session) considered 842 proposals. A total of 126 of these measures were of interest to the medical profession. Despite the heavy pressure of activity which marked the concentrated four-month session, no bills became law which might tend to lower the high standards of Medicine in Michigan.

Two measures of vital importance to the Michigan State Medical Society and to the practice of medicine were enacted; these contained amendments to the Basic Science Act and the Medical Practice Act as desired by the 1951 MSMS House of Delegates.

All other important legislation, which benefitted the health of the residents of Michigan, was supported by MSMS.

Bills Passed by the Legislature

S.B. 251—

Amendments to Basic Science Act.—All changes in the Basic Science Act as recommended by the 1951 MSMS House of Delegates were included in this bill adopted by both Houses of the Michigan Legislature.

Changes: The Basic Science Board is now permitted to approve those applicants who have successfully passed the basic science examinations in practically any other "basic science" state. The Act was amended to omit the examination in "public health and hygiene." Interns and residents are now exempt from the Basic Science Examination. Subjects passed successfully need not be taken again where the applicant fails in one or more subjects. The membership of the Basic Science Board will be subject to change (service limited to 2 consecutive six year terms). The records of the board—in respect to the reason for approval of applicants—will be open to public inspection. Public Act 198.

S.B. 301—

Amendments to Medical Practice Act.—This bill, containing changes as recommended by the 1951 MSMS House of Delegates, was passed by the Legislature with only two minor amendments which were not opposed by the Michigan State Medical Society.

The principal changes involve the deletion of obsolete language regarding the appointment of members of the Board of Registration in Medicine, the number of Board members necessary to transact business, and the dates for such business; the Board will now consist of ten doctors of medicine, nine of whom are to be from the "regular" school of medicine and one to be a graduate of a homeopathic school. The other adjustments in the bill reduced the passing grade from 75 to 70 per cent; doubled the present fees, to give additional funds to the Board for administrative purposes; allowed the Board to grant and revoke temporary annual licenses to residents in hospitals which may be renewed; extended the statutory definition of unprofessional and dishonest conduct, to include doctors guilty of "claims . . . to cure . . . by secret methods"; the Board to suspend licenses when a doctor has been adjudged mentally incompetent. An amendment requiring applicants to show evidence of being either a citizen of the United

States or of having valid second naturalization papers was added by committees in the House and Senate. The bill was given immediate effect and became law on April 25, 1952. Public Act 172.

S.B. 317—

Franchise Tax.—This bill as originally written included Blue Cross-Blue Shield plans and would have imposed a privilege fee or tax of five mills on each dollar of their assets with a ceiling of \$50,000. Blue Cross-Blue Shield was removed from this measure before it was passed. (See S.B. 328, below). Public Act 180.

S.B. 240—

Permissive Licensure of Practical Nurses.—For the first time, practical nurses are given an opportunity to be licensed if they meet certain qualifications. The Michigan Board of Nursing will now include three licensed practical nurses who will serve only on matters affecting licensed practical nurses. Public Act 135.

S.B. 55—

State Health Laboratory, Grand Rapids.—Under the provisions of this bill, agreements were authorized between the State Administrative Board and the City of Grand Rapids for the building of a state health laboratory in Grand Rapids. Public Act 15.

H.B. 63, 65,
66, and 69—

Sex Deviates.—These bills, dealing with sex deviate problems, were the result of recommendations from the Governor's Study Commission. They were concerned with the criminal sexual psychopath, indeterminate sentences and sex deviation crimes. The principles of these measures were developed with the co-operation of the MSMS Mental Hygiene Committee. Public Acts 58, 73, 234, and 72. (See H.B. 64 and H.B. 67, below).

H.B. 297—

Births and Deaths Registrations.—This bill consolidates registration districts keeping records of births and deaths. Public Act 65.

H.B. 278

S.B. 294—

Dairy Products Inspection.—These measures established systems for inspecting and licensing of dairy products. They divide the responsibility between the State Health Department and the State Department of Agriculture. Public Acts 258 and 238.

H.B. 172—

Community Hospitals.—As passed, this bill allows for construction and operation of a community hospital by one or more cities, villages or townships acting jointly. Public Act 170.

H.B. 166—

Minimum Standards, Children's Welfare Agencies and Boarding Homes.—Minimum standards of care, personnel, food, sanitation and fire protection which can be enforced by Circuit Courts are provided for in this bill. Public Act 47.

S.B. 92—

Narcotics.—This bill abolishes distinction in penalties for selling or administering narcotics illegally to minors or adults. Public Act 132.

ANNUAL REPORT

H.B. 423
H.B. 449—

Amendments to Crippled and Afflicted Children Acts.—These measures provide changes in collection requirements for monies to reimburse the state. The cases are to be reviewed every three years; investigations to be made by the Michigan Department of Social Welfare. Public Acts 245 and 244.

H.B. 202—

Osteopathy.—A bill to permit license renewal by compliance with requirement for attendance at eight hours of educational courses as prescribed by the State Board of Osteopathic Examiners. Public Act 93.

Workmen's Compensation.—

Sixteen Workmen's Compensation bills were entered in the House and Senate. Each bill was carefully reviewed by the MSMS through industrial and labor advisors. These bills were: S.B. 31, 112, 173, 188, 193, 293, and 314. H.B. 38, 51, 156, 160, 174, 226, 277, 314, and 325. Those which passed are: S.B. 193, (P.A. 155); H.B. 226, (P.A. 77); H.B. 314, (P.A. 107); and H.B. 325, (P.A. 263). The MSMS had no major objection to any of those which passed.

Bills Which Failed to Pass the Legislature

H.B. 358—

Repeal of Basic Science Act.—A perennial. Died in House State Affairs Committee.

H.B. 183—

Chiropractic Proposal.—Chiropractors' bill to legislate themselves into the practice of medicine. Failed to come out of House Public Health Committee.

H.B. 184—

Chiropractic Use of State Laboratory.—The chiropractors' companion bill to H.B. 183 which would have opened the State laboratories to all of the healing arts. This was killed in the House Public Health Committee.

H.B. 400—

Naturopathy.—Would have legalized naturopathy by establishing a board of registration, defining educational requirements, etc. A perennial. Died in House Public Health Committee.

S.B. 69—

Little Hoover Commission's "Umbrella" Bill re Health Agencies.—Proposed to transfer to the Michigan Department of Health the power and duties of the Crippled Children Commission, Tuberculosis Sanatorium Commission and TB Hospitals, Mental Health Department and mental hospitals, Social Welfare Department concerning maternity or lying in hospitals. Due to considerable objection, this all-encompassing proposal to create a gigantic state bureau with almost unlimited control over health matters in Michigan died in the Senate State Affairs Committee.

S.B. 265—

Hospital Cost Commission.—This bill sought to create a hospital cost commission to consist of the auditor-general, state health commissioner and comptroller of the State for the purpose of establishing annually the per diem costs for services performed by hospitals to patients who are the direct responsibility of the State. Since this proposal involved the expenditure of considerable funds, the bill was re-referred to the Senate Committee on Appropriations. The Session ended before the Committee concluded its study of the proposal.

S.B. 328—

Tax on Blue Cross-Blue Shield.—Introduced for the purpose of specifically taxing medical care and hospital service corporations (Blue Cross and Blue Shield Plans) by a tax of 1c per subscriber contract. The bill was killed on the floor of the Senate by a narrow margin.

S.B. 26—

State Medical Examiner System.—This bill to create a medical examiner system and to abolish the office of coroner died in the Senate Judiciary Committee. Despite the fact that it was not reported from the Committee, much more interest in this progressive proposal was indicated by the 1952 Legislature than in prior sessions.

H.B. 286—

Wayne County Medical Examiner Bill.—Would have established a county medical examiner system in Wayne County; it was amended to include all counties with 150,000 population or over. Would have abolished the coroner's office. This bill abolishing the county coroner's office, passed the House, with great difficulty, but failed in the Senate.

Senate Concurrent Resolution 39—

Violent and Unexplained Deaths, Investigation.—Senator Perry Greene offered a resolution providing for an interim committee of the Legislature to study the advisability of new legislation to improve the investigation of violent and unexplained deaths. This resolution died in Committee on Senate Business and Rules.

S.B. 64—

Optometric Measure.—This bill prohibited the prescribing or selling of eye-glasses except by registered optometrists and M.D.s and prevented practice of optometry by lay groups and organizations. This proposal was strongly opposed by dispensing opticians and the medical profession. The bill died in the Senate State Affairs Committee.

H.B. 175—

Optometry Advertising.—Would have prohibited the advertising of eye-glasses by optometrists and defined other unlawful conduct. Passed the House but failed to come out of the State Affairs Committee in the Senate.

H.B. 49—

Flour Enrichment.—This bill would have provided for the enrichment of white flour. It successfully passed the House but due to strong objections failed to come out of the Senate Committee.

Senate Joint Resolution "A"—

Reapportionment of Legislature.—This provided for proposal on the ballot of a reapportionment of the Michigan Senate and House of Representatives; the change would provide 34 Senators and 110 Representatives on a geographical and population basis. The bill passed the Senate and failed in House due to requirement of $\frac{2}{3}$ majority necessary to pass.

H.B. 453—

Autopsies.—A bill to clarify the legal requirements of autopsies, postmortems or dissections. Failed to come out of House State Affairs Committee.

S.B. 291—

Mental Health Commission.—This bill would have revised the Mental Health Commission to consist of a psychiatrist, physician, attorney-at-law and two members to represent the public. Required a psychiatrist as Director and provided Deputy Director as business manager. Died in Senate Health and Welfare Committee.

ANNUAL REPORT

S.B. 313—

Advisory Hospital Council Membership.—This proposal would have removed the requirement providing for appointment of a full time health officer from a list submitted by the Michigan Health Officers Association. If this measure had passed, the Governor could have appointed any health officer to this Council regardless of the Michigan Health Officers Association list. Senator Frank Heath, of Bay City, sponsored this bill.

H.B. 64
and 67—

Sex Deviate.—Part of the original group dealing with sexually motivated crimes and the mentally ill. Both bills passed the House but failed to pass the Senate.

S.B. 109—

Physically Handicapped—Labor Department.—Would have created a state advisory council within the Department of Labor for the purpose of advising all agencies of state government dealing with problems of the physically handicapped (including crippled and afflicted children). Failed to come out of Senate State Affairs Committee.

H.B. 360—

75 Per Cent Passing Grade for M.D.s.—This bill would have required at least a 75 per cent passing grade for specified subjects in medical licensure examinations. A perennial. Died in House Public Health Committee.

S.B. 85—

Forensic Medicine.—Would have provided for a post-mortem examination following death by poison, violence or criminal act; also provided for taking of blood samples to determine the degree of alcohol in blood when intoxication may have been the cause of death. Failed to come out of Senate Judiciary Committee.

S.B. 65—

Migratory Labor.—Would have required migratory agriculture workers to carry or furnish a certificate of non-affliction of tuberculosis. Reported out by the Senate Judiciary Committee but re-referred to the Senate Health and Welfare Committee where it died.

Resolution re

Reapportionment.—A House resolution (HJR-C) to establish a joint committee for the study of the reapportionment problem in the State of Michigan failed to come out of committee. HJR-G a House companion resolution to SJR "A" was reported from Committee but was laid on the table due to failure to obtain $\frac{2}{3}$ majority vote.

H.B. 80—

Eleemosynary Status; Defense for Negligence.—A bill to abolish any defense for negligence based on charitable, eleemosynary or non-profit character of organization. Not passed by House.

H.B. 101—

Temporary Detainment of Mentally Ill.—To provide temporary detainment of mentally diseased persons in state hospital for custody and treatment. Passed the House but remained in Senate Health and Welfare Committee.

H.B. 197—

Drugs.—A bill to make it unlawful to compound or sell substitutes or alternative drugs or medicines specified in prescriptions. This measure failed to come out of House Public Health Committee.

H.B. 220—

Aid to Indigent Patients.—A bill to give aid to patients in public and private medical institutions who are now excluded from receiving aid because of limitations on federal funds—(bill excluded tuberculosis or psychosis patients). Did not get out of House Social Aid and Welfare Committee.

Appropriations

1. The total state budget provided \$6,000,000 for the care of state-at-large tuberculosis patients; \$1,243,393 for the TB Sanatorium at Howell; \$256,227 for Pincrest Sanatorium at Ostemo; \$439,393 for Northern Michigan Sanatorium at Gaylord; and \$292,563 for the Copper Country Sanatorium at Hancock. The Legislature also approved the "borrowing" of \$2,500,000 from the hospital bond issue money for construction of a new 250-bed tuberculosis treatment wing at Herman Kiefer Hospital, Detroit.

2. The Legislature voted \$225,000 to rehabilitate the Basic Science building at Michigan State College and \$1,000,000 to continue construction of a Medical Science building at Wayne University. Appropriations for the University of Michigan included \$325,000 for rehabilitation of the Natural Science building, \$16,000 for plans for rehabilitation of the present out-patient clinic, and \$726,800 to complete a new out-patient clinic.

3. Funds appropriated for the operation of state-supported mental institutions included \$2,219,884 for Caro State Hospital, \$1,423,966 for Ionia State Hospital, \$4,027,706 for Kalamazoo State Hospital, \$2,158,379 for Newberry State Hospital, \$3,826,405 for Pontiac State Hospital, and \$4,303,873 for Ypsilanti State Hospital.

Thanks

The Legislative Committee extends sincere appreciation to all Doctors of Medicine who aided the MSMS Legislative program of 1952—true thanks for splendid co-operation and constant help. This back home support with our Senators and Representatives insured success. This was a vitally important session because the MSMS House of Delegates had requested the passage of measures pertaining to changes in the Medical Practice Act and the Basic Science Act. That these bills were passed as directed in the 1951 House of Delegates recommendations is proof that the efforts of individual doctors with Legislators results in improved medical services for the people of this state. The Michigan medical profession thanks its friends in the Legislature for their activities which forwarded good health in Michigan.

Respectfully submitted,

L. A. DROLETT, M.D., *Chairman*
G. V. CONOVER, M.D.
J. H. FVIE, M.D.
J. R. PEDDEN, M.D.
R. V. WALKER, JR., M.D.
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AUTHORS	No. of Patients	Chronic, Resistant to Other Therapy	TYPES OF ULCERS				RELIEF OF SYMPTOMS (Chiefly Pain)				Surgery or Complications ¹	Side Effects Requiring Discontinuance of Drug ²	EVIDENCE OF HEALING			
			Duodenal	Jejunal	Stomal	Gastric	Good	Fair	Poor	No Report			Complete	Moderate	None	No Report
Grimson, Lyons, Reeves	100	100	93	7			80	11	4		5		47		19	29
Friedman	15	15	14			1	5		4	6 ³			2			13
Bechgaard, Nielsen, Bang, Gruelund, Tobiasen	26	26	21			5	16	4	6				8	6	12	
McHardy, Browne, Edwards, Marek, Ward	162		162				136	12	11		3	1	14	9	7	129
Segal, Friedman, Watson	34	34	34 ⁴				14	13			7	2	5		8	14
Brown, Collins	117	99	117				97	7	8		5	8	55	9	8	40
Asher	77		65		7	5	52	9	16			16		9	21	47
Rodriguez de la Vega, Reyes Diaz	5	4	5				4		1					3	2	
Winkelstein	116	116	102	8		6	102		14				53		18	45
Hall, Hornisher, Weeks	18	18	18				11		1	6 ⁵			18			
Maier, Meili	38	38	24			14 ⁴	27	7	4 ⁷				10	2	5	21
Meyer, Jarman	25	18	25				21		4							25
Poth, Fromm	37	37	37				33	3	1				33	3	1	
Plummer, Burke, Williams	41	41	41				36		5				38		3	
McDonough, O'Neil	104	100	104				63	10	31			11	4		11	89
Broders	60	60	58		1	1	35	19	6				10	1	49 ⁸	
Legerton, Texter, Ruffin	11		11				11									11
Holoubek, Holoubek, Langford	76	69	76				35	27	10		4	10	26		10	36
Ogborn	42		39	2		1	42 ⁹									42
Shaiken	48	48	48				33	10	3		2		33	10	3	
Johnston	145	145	145				143		2			2	143		2	
Rossett, Knox, Stephenson	146		141			5	146					4 ¹⁰	53			93
TOTALS	1443	968	1380	17	8	38	1142	132	131	12	26	54	552	52	179	634
PERCENTAGES		67.8	95.6	1.2	0.6	2.6	81.3	9.4	9.3			3.7	70.5	6.6	22.9	

1. Not included in tabulations.

2. Included in "Relief of Symptoms" as "Poor" and in "Evidence of Healing" as "None."

3. Four had no symptoms when Banthine therapy was begun.

4. Of which seven were penetrative lesions and five partially obstructive.

5. No symptoms were present in four.

6. Two with symptoms only; no demonstrable ulcer.

7. Three were psychopathic patients and one had a ventricular ulcer of the lesser curvature.

8. Roentgen findings after treatment period of two weeks; forty-seven had duodenal deformity.

9. All returned to work within a week.

10. In these four, after relief of symptoms, Banthine was discontinued because of urinary retention.

During the past two years, more than 200 references to Banthine therapy in peptic ulcer and other parasympathotonic conditions have appeared in medical literature. Of these reports, 22 have presented specific facts and figures on the results of treatment in a total of 1,443 peptic ulcer patients, 67.8 per cent of whom were reported as chronic or resistant to other therapy. These results are tabulated above and show:

"Good" relief of symptoms was obtained in 81.3 per cent of the 1,405 patients on whom reports were available.

"Complete" evidence of healing was obtained in 70.5 per cent of the 883 patients on whom reports were available.

In all but 9.7 per cent, relief of pain was "good" or "fair." In all but 22.9 per cent, evidence of healing was "complete" or "moderate."

During treatment, 26 patients required surgery or developed complications other than ulcer which required discontinuance of the drug before results could be evaluated.

Of the remaining 1,417 patients, only 3.7 per cent experienced side effects sufficiently annoying to require discontinuance of the drug.



*Volume containing complete references, with abstracts of 39 additional reports, will be furnished on request by

G. D. SEARLE & Co., P. O. Box 5110, Chicago 80, Illinois.

Michigan's Department of Health

Albert E. Heustis, M.D., Commissioner

The amendment to the registration law which went into effect May 1 consolidated the unincorporated portions of the townships of each county and designated the county clerks as registrars of these new primary registration districts. As a result of the amendment, duties of township clerks that have to do with registration of births, deaths and stillbirths and the issuance of burial-transit permits were transferred to county clerks. The status of city and village registrars was not affected.

The legislation leaves 602 registrars, 1,177 less than formerly, for unincorporated areas of the county, for cities and villages and for state hospitals, charitable and penal institutions. This change from a large number of small registration districts to a smaller number of larger districts is a logical result of improvement in transportation and hospital facilities.

* * *

A progress report on the special venereal disease and tuberculosis survey being carried on in Detroit shows that from May 1, when the survey started, to May 7, a total of 3,147 persons had had blood tests and 3,555 had been given chest x-rays. One of the areas in which the work is being concentrated had a 1950 tuberculosis death rate of 96.8 in comparison with the rate of 19.9 for the state.

* * *

A recent reprint from the Congressional Record of the speech of a Congressman on fluoridation of public water supplies has brought inquiries to the Department from many parts of the United States. The Congressman quoted statistics to prove that deaths in Grand Rapids from heart disease, nephritis and intra-cranial lesions had increased 50 per cent since the city's water supply had been fluoridated. The period he cited was from 1944 to 1948.

A simple but serious mistake in reading base-line data apparently accounts for the Congressman's conclusions. He compared the 1944 figures for Grand Rapids with the 1948 figures for all of Kent County.

Check of the vital statistics figures to which the Congressman refers shows that deaths from heart disease in Grand Rapids in 1944 totaled 585 as compared with 726 for 1948. This is an increase of about 25 per cent but, as Dr. Prothro, Grand Rapids Health Director, points out, the population increase was 25 per cent for the same period. Nephritis and intra-cranial lesions showed normal fluctuations.

Judging from the comments coming to the Section of Public Health Dentistry of the Department, fluoridation of water supplies to prevent tooth decay among children is going through the same cycle followed by vaccination against smallpox and, in fact, all immunization procedures, and pasteurization of milk. In the present situation, a small group of vocal opponents offers claims

ranging from statements that the fluoridation of water is socialistic to assertions that it is "a master plan to wreck the United States." Medical and dental authorities rest their case on evidence over the years that people drinking naturally fluoridated water have little tooth decay, and on experimental programs such as that in Grand Rapids where fluoridation of the public water supply begun in 1945 has resulted in a reduction in tooth decay of approximately 60 per cent in children five through eight years of age and of 25 per cent in boys and girls nine through sixteen.

Their contention that fluorine in the recommended concentration is harmless is based on exhaustive laboratory studies and also on studies of individuals living throughout life in communities whose water supplies contain fluorides.

* * *

W. B. Prothro, M.D., is director of the Grand Rapids City Health Department, appointed on April 14 to succeed C. C. Slemons, M.D., who retired after forty-three years of outstanding service to public health in Michigan. Dr. Prothro resigned as director of the Kalamazoo City-County Health Department to accept the Grand Rapids position. Norma Anderson, M.D., has been appointed acting director of the Kalamazoo City-County Health Department to serve until a full-time director is chosen.

* * *

For the second summer, the Department is conducting a state-wide, self-supporting program of topical fluoride applications that will combine treating the teeth of children with training of junior dental and dental hygiene students from the University of Michigan.

Beginning in June and continuing through August, twenty-seven students will work in sixty-eight communities throughout the state. This is an increase of ten students over the number participating in a similar project last summer. Portable dental equipment will be supplied by the Department and the Public Health Service.

Children in these sixty-eight communities will be offered sodium fluoride treatments of their teeth at a minimal charge. Any child not able to pay will be treated free. Fees will be sufficient to pay living expenses of the students and to provide expendable supplies. Local dentists will supervise the work in each community and local health departments, schools and parent groups will co-operate in making arrangements and carrying them through. Last summer, 5,700 children were given treatments and the expanded program this summer is expected to reach over 12,000 children.

* * *

The number of births in Michigan in 1951 broke all records. Provisional figures show 171,568 live births recorded as compared with 160,275 for 1947, the previous high year.

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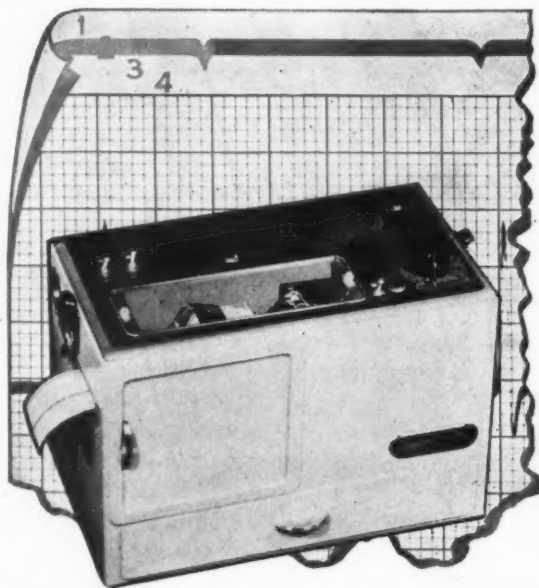
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Correspondence

Lansing, Michigan

To: All Michigan Physicians

Act No. 65, P.A. 1952, Imd. Eff., consolidates the unincorporated portion of the townships of each county as a primary registration district and designates the county clerk of each county as registrar of the consolidated area. Effective May 1, 1952, those parts of the duties of the township clerks that have to do with the registration of births, stillbirths, and deaths, will be transferred to the county clerk. It will, therefore, be necessary for you in the future to file birth certificates for those births that occur in the unincorporated parts of the townships with the county clerk instead of the township registrar.

Act No. 65 does not affect the status of village or city registrars so that the record of live births occurring in hospitals or in homes within the limits of an incorporated city or village will be filed with the registrar in whose jurisdiction the event occurred just as was the custom in the past.

ALBERT E. HEUSTIS, M.D., Commissioner
Michigan Department of Health

April 23, 1952

New York, N. Y.

Dr. Wilfrid Haughey
Battle Creek, Michigan

Dear Dr. Haughey:

Thank you so very much indeed for devoting the April cover of your publication to the Cancer Crusade. The cover is extremely striking and we are most appreciative of your generosity in giving us this coveted space.

Sincerely yours,
SANDRA MUNSELL, Supervisor
Magazine Advertising Services
American Cancer Society, Inc.

May 9, 1952

L. Fernald Foster, M.D., Secretary
Michigan State Medical Society
Lansing 15, Michigan

Dear Dr. Foster:

The Hillsdale County Medical Society wishes to take this opportunity to express to the Michigan State Medical Society its appreciation for the recognition of its work in tumor detection by the presentation of a beautiful scroll at the Spring Session in Detroit on March 13. The scroll now hangs in the Society's meeting room at the Hillsdale Community Health Centre, and makes us feel very proud of our small part in helping the State Society in its great work of fighting cancer by early detection.

Very truly yours,
ARTHUR J. STEIN, M.D.
Secretary, Hillsdale County Medical Society
Hillsdale, Michigan

April 11, 1952

New York, N. Y.

Dr. Wilfred Haughey, Editor
THE JOURNAL, Battle Creek, Michigan

Dear Dr. Haughey:

A patron of the Society for the Prevention of Asphyxial Death Inc., interested in making the causes and prevention of asphyxia better known among physicians of Michigan State, has kindly offered to donate a copy of the Art of Resuscitation, by Paluel J. Flagg, M.D., to the first 100 physicians who become members of the Society following the release of this information in THE JOURNAL of the Michigan State Medical Society.

JMSMS

CORRESPONDENCE

The book lists for \$6.00. Volumes donated will be autographed by Dr. Flagg.

Physicians who wish to receive this autographed volume for their library are asked to apply for membership in the Society for the Prevention of Asphyxial Death Inc. enclosing membership dues of \$5.00. Communications should be addressed to, Secretary, SPAD Inc., 2 East 63 Street, New York 21, New York.

Dr. Chevalier Jackson in the preface of this book says, "To learn from this book means to save human lives."

May we ask your co-operation in publicizing the offer of our patron to the end that Dr. Jackson's belief may become more completely realized in the State of Michigan?

Very sincerely yours,

J. RICHARDSON, *Secretary, SPAD*

Wilfrid Haughey, M.D., Editor

THE JOURNAL MSMS
Battle Creek, Michigan

Dear Dr. Haughey:

We have recently received a copy of the February, 1952, issue of THE JOURNAL of the Michigan State Medical Society. You can imagine how pleased all of us here at the National Society were to see the excellent display on your front cover plugging our 1952 Easter Seal Campaign. We also appreciate your using the editorial we supplied you with which appears on page 164, and also like the publicity given to our 1952 convention appearing on page 249. This certainly can be regarded as a National Society issue and we want you to know how much we appreciate your splendid co-operation.

Again, thank you for your wonderful contribution on behalf of crippled children.

Cordially yours,

ALVIN BERNSTEIN, *Consultant
Information Service, National
Society for Crippled Children
and Adults, Inc.
Chicago 3, Illinois*

April 7, 1952

Mr. William J. Burns, Executive Director
Michigan State Medical Society
Lansing 15, Michigan

Dear Bill:

You are of course familiar with the resolutions that have been passed by the House of Delegates in past years dealing with the deductibility, for federal income tax purposes, of the expenses incurred by physicians for post-graduate work.

From time to time we have attempted to induce the Commissioner of Internal Revenue to reconsider and reverse the old opinion disallowing the deductibility of such expenditures but have not met with any success.

During the early part of this year, we retained special counsel in Washington to prosecute this question for us to a satisfactory conclusion. It was discovered that there was pending before the U. S. Tax Court a case in which a lawyer had been denied the right to deduct certain expenditures made by him in attending a series of lectures given by the New York University Institute on Federal Taxation. This case involves the same issue in which physicians are interested and our tax counsel requested and obtained permission from the Court to file a brief for the American Medical Association as amicus curiae.

No conclusion has been reached by the Court as of this date.

Sincerely yours,

J. W. HOLLOWAY, JR.
AMA Bureau of Legal Medicine and Legislation
Chicago 10, Illinois

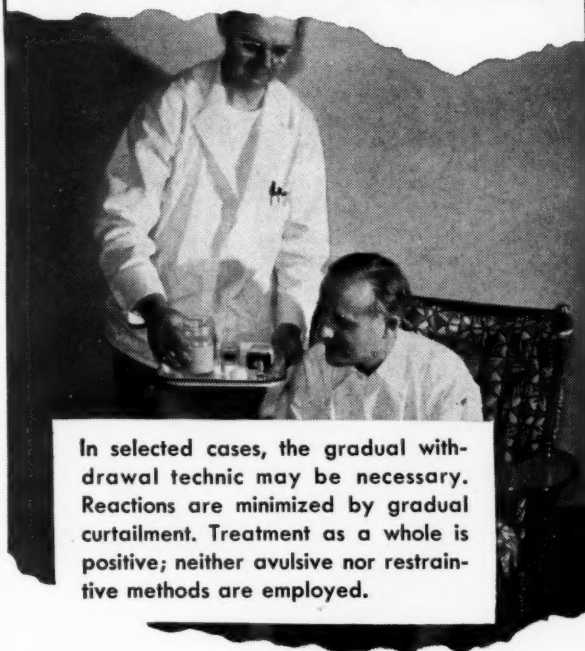
April 14, 1952

JUNE, 1952

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In Memoriam



R. M. KEMPTON, M.D.

ROCKWELL M. KEMPTON, M.D., of Saginaw, died April 5 at the age of sixty-three.

For the past thirty-two years he had served the community of Saginaw twenty-seven years as a pediatrician. He was graduated from the University of Michigan Medical School in 1918 and served his internship and residency in the University of Michigan Hospital.

He pursued additional postgraduate work at Boston Floating Hospital.

The first five years Dr. Kempton was in Saginaw he devoted himself to the general practice of medicine. In 1925, after postgraduate work, he limited his work to pediatrics. Dr. Kempton established pediatric departments at Saginaw General Hospital and St. Mary's Hospital and for the past 25 years served as chairman of the departments.

In commenting on outstanding contributions made by Dr. Kempton, *The Bulletin* of the Saginaw County Medical Society reported:

"In the early thirties, before it was commonly done in the large medical centers, newborn care was recognized in Saginaw as a pediatric, not an obstetrical problem. With this premise Dr. Kempton took over the supervision of the newborn nurseries in the hospitals in the city. This was a pioneer activity which has since been accepted nationally. We must give to him the credit of developing an accredited residency program at the Saginaw General Hospital for teaching residents in pediatrics."

Dr. Kempton also helped establish the Saginaw Valley Children's Center. This Center, organized in 1942, was the third established in Michigan. Dr. Kempton was a member of its original board of directors.

He was an active member of the Saginaw County Medical Society and served as its president in 1932. In 1949, he was head of the Saginaw County Public Health Association. He was also a director of the Saginaw Community Chest. He was also greatly interested in the history of Saginaw Valley, Indian lore and archeology.

Dr. Kempton was a Diplomate of the American Board of Pediatrics and a member of the American Academy of Pediatrics, American College of Physicians, the University of Michigan Pediatric Society and the Detroit Pediatric Society.

Dr. Kempton also contributed his time and talent to the Michigan State Medical Society. He was chairman of the MSMS Child Welfare Committee from 1947 to 1949. He also served as a lecturer in pediatrics at clinical sessions of the state society.

In addition, Dr. Kempton was the author of numerous medical papers and articles.

Two memorials to Dr. Kempton have been established at Saginaw General Hospital and St. Mary's Hospital.

IN MEMORIAM

The Saginaw General Hospital memorial is a continuing scholarship for nurses in postgraduate and postgraduate pediatric training. The second memorial at St. Mary's Hospital is the Rockwell M. Kempton Pediatric Library.

As a fitting tribute to a beloved member, the members of the Saginaw County Medical Society eulogized Dr. Kempton in sincere words fitting the high accord in which he was held within his community:

"Rockwell M. Kempton will long be remembered for love of his fellow men, his kindly counsel, and gentle understanding when people from all walks of life came to him with their problems. His greatest fear was of hurting someone. When decisions were to be made, he would first review his thinking before stating his position to be sure that the decision would be a constructive one—one which would make no person suffer. He was devoted, always, to his family, friends, colleagues, and patients and will ever be remembered by all of them as a thoughtful, kindly physician."

WILBERT B. CLARK, M.D., a Life Member of the Michigan State Medical Society, died March 30 at the home of a son in Kenmore, New York, at the age of eighty-four.

Dr. Clark received his medical degree from the Michigan College of Medicine and Surgery, Detroit, in 1894. He began his practice of medicine at St. Louis and remained there until 1903 when he moved to Saginaw. Dr. Clark had actively practiced medicine for fifty-two years before his retirement in 1946. In addition to his practice in Saginaw he served as Saginaw County health officer and as City Physician, and for eight years as Coroner.

Dr. Clark is survived by his wife, Elizabeth; and two sons, Kenneth and Leland.

GEORGE O. McDONALD, M.D., of Detroit, died April 8 at Thamesford, Ontario, at the age of sixty.

Until his retirement six months ago, Dr. McDonald had engaged in the general practice of medicine in Detroit since 1926. He was a former member of the staff of Mt. Carmel Mercy Hospital.

Dr. McDonald was graduated from the University of Toronto Faculty of Medicine in 1920. He was a member of the Wayne County Medical Society and of the Michigan State Medical Society and a fellow of the American Medical Association.

CHARLES C. ENGLEHART, M.D., of Houghton, died March 26 at the age of fifty-two.

For the past year and a half, Dr. Englehart had served the community of Houghton as an ophthalmologist-otologist. Previous to coming to Houghton, Dr. Englehart had practiced in Harrisburg, Pennsylvania, following his graduation from Temple University School of Medicine in 1931.

Dr. Englehart served his internship at the Harrisburg Poly-Clinic. His postgraduate studies were conducted at

(Continued on Page 788)



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NEWS MEDICAL

MICHIGAN AUTHORS

William C. Baum, M.D., of Ann Arbor, is the author of an article, "Physiology of the Male Reproductive Tract," published in *The Student American Medical Association Journal*, April, 1952.

John R. Rodger, M.D., of Bellaire, is the author of an article, "Rural Practice Can Be Fun," published in *The Student American Medical Association Journal*, April, 1952.

Lida A. Mattman, Ph.D., of Detroit, is one of the authors of the article, "Rhinoscleroma Successfully Treated with Streptomycin," published in *The Journal of the American Medical Association*, February 23, 1952, and abstracted in the *Digest of Ophthalmology and Otolaryngology*, April, 1952.

J. H. Maxwell, M.D., of Ann Arbor, is the author of an article, "Extra Temporal Repair of the Facial Nerve—Case Reports," in the *Annals of Otolaryngology, Rhinology and Laryngology*, December, 1951.

J. H. Maxwell, M.D., and R. W. Waggoner, M.D., are the authors of an article, "Hypertrophy of the Masseter Muscles," in the *Annals of Otolaryngology, Rhinology and Laryngology*, November, 1951.

Henry Archambault, M.D., and Rene Archambault, M.D., of Detroit, are the authors of an article, "Leiomyoma of the Common Bile Duct," published in the *Archives of Surgery*, April, 1952.

Grover C. Penberthy, M.D., and Clifford N. Benson, M.D., are the authors of an editorial, "Injuries to the Abdomen in Industry," reprinted from the *American Journal of Surgery*, 1947, and published in *Surgery, Gynecology and Obstetrics*, May, 1952.

Leland F. Carter, M.D., of Detroit, is the author of an article, "Progressive Essential Atrophy of the Iris," published in the *American Journal of Ophthalmology*, April, 1952.

Samuel J. Nichamin, M.D., of Detroit, is the author of an article, "Pleurodynia in Children—Clinical Observations in Fifty-Four Cases," published in *The Journal of the American Medical Association*, March 22, 1952.

Herbert I. Kallet, M.D., and Lavelle Patrick Davlin, M.D., of Detroit, are the authors of an article, "Anal Irritation Following the Use of Antibiotics," published in *The American Practitioner Digest of Treatment*, May, 1952.

To the M.D. who contributed \$5.00 cash for the Beaumont Memorial Restoration on the occasion of the Michigan Clinical Institute in Detroit last March:

Through a loss in shipment of records from Detroit to Lansing, the card indicating your \$5.00 cash contribution has been lost or mislaid. Would you please report your name and address to the Beaumont Memorial Restoration Committee, 606 Townsend Street, Lansing, Michigan? The Committee wishes you to receive full credit for your contribution.

OTTO O. BECK, M.D.,
MSMS President.

Recent appointments to the Michigan State Board of Registration in Medicine for terms expiring September 30, 1955, were: W. C. Behen, M.D., Lansing, J. T. Bertucci, M.D., Ishpeming, Paul G. Hanna, M.D., St. Joseph, J. E. McIntyre, M.D., Lansing (reappointed), O. D. Stryker, M.D., Mt. Clemens.

* * *

Members of the Wayne County Medical Society are being polled by the WCMS Council on the following questions:

1. Are you in favor of a geographical telephone listing?
2. Do you believe the Wayne County Medical Society should operate a telephone exchange service?

The Wayne County Medical Society has a "Medical Service Bureau" which answers an average of 184 emergency calls per month, but the Society feels the service is inadequate: (1) because there are too few doctors who actually accept emergency calls when requested; (2) it is too difficult to locate physicians, especially between 11:00 a.m. and 1:00 p.m.

Through the establishment of a telephone message exchange, WCMS believes that it will be able to provide quicker and more adequate service because it will be easier to locate a physician, since complete information on his regular schedule would be available and the doctor would contact Society headquarters when contemplated changes in his daily routine are planned; further, the Society would have a closer contact with all of those who subscribe to the exchange.

"Since it is planned to correlate the exchange with the emergency service, it would undoubtedly result in more physicians participating in the emergency program of the Society," states the *Detroit Medical News* of April 21, 1952.

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60 days in Hospital.....	5.00 per day	10.00 per day	15.00 per day	20.00 per day
30 days of Nurse at Home.....	5.00 per day	10.00 per day	15.00 per day	20.00 per day
Laboratory Fees in Hospital.....	5.00	10.00	15.00	20.00
Operating Room in Hospital.....	10.00	20.00	30.00	40.00
Anesthetic in Hospital.....	10.00	20.00	30.00	40.00
X-Ray in Hospital.....	10.00	20.00	30.00	40.00
Medicines in Hospital.....	10.00	20.00	30.00	40.00
Ambulance to or from Hospital.....	10.00	20.00	30.00	40.00

DISABILITY COSTS (Quarterly)

Adult	2.50	5.00	7.50	10.00
Child to age 19.....	1.50	3.00	4.50	6.00

\$5,000 accidental death Quarterly \$8.00
\$25 weekly indemnity, accident and sickness

\$10,000 accidental death Quarterly \$16.00
\$50 weekly indemnity, accident and sickness

\$15,000 accidental death Quarterly \$24.00
\$75 weekly indemnity, accident and sickness

\$20,000 accidental death Quarterly \$32.00
\$100 weekly indemnity, accident and sickness

COST HAS NEVER EXCEEDED AMOUNTS SHOWN

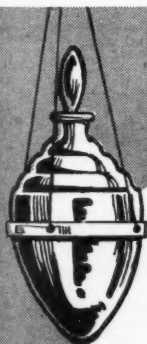
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NEWS MEDICAL

David I. Sugar, M.D., Associate Editor of the *Detroit Medical News*, blasts the outmoded governmental and labor union idea that retirement must begin at sixty-five. His editorial in the *Detroit Medical News* of April 21, entitled "64 years and 364 days" indicates that this period "is a variable and shifting milestone. While in some it postdates an era, in many it is but another day in a busy useful life."

Congratulations, Dr. Sugar, on a forthright, sensible and modern statement of fact. Your editorial reflects the considered thinking of the MSMS Geriatrics Committee on this subject.

* * *

The Bulletin of the Saginaw County Medical Society (April 15, 1952) contains the following item in connection with a regular meeting of Saginaw County Medical Society held March 25, 1952: "A new policy of several insurance companies whereby payment is made for house and office calls was discussed. It was stated that a great deal of paper work is involved in this matter and that it is becoming a considerable burden to handle. The matter was referred to the Economics Committee with the request to report at the next meeting."

* * *

"Indifference is the most deadly and damning sin of our time. In my judgment, the curse of our times is that we have so many 'good' people who believe the right things and never do anything about them."—KENNETH McFARLAND, Ph.D., of Topeka, Kansas, at AAGP Annual Assembly Banquet, Atlantic City, March 27, 1952.

Flood victims are being aided by Eli Lilly and Company, with replacement of all Lilly products in pharmacies and hospitals ravaged by the flood in the Missouri and Mississippi River Valleys. Lilly representatives in a dozen states, from Montana to Missouri, have been directed to make the replacement of flood-damaged Lilly pharmaceuticals and biologicals their first order of business. Eli Lilly and Company has been replacing stocks damaged by uninsurable hazards as far back as the 1906 San Francisco disaster.

* * *

From the Grocery Manufacturers of America comes this most startling thought . . . Citizens of the United States now pay more money for taxes than for all the food they eat . . . In 1950 taxes cost \$57 billion . . . food, \$52 billion.

* * *

Something to Vote About: The voters in leading countries exercise their right of franchise (according to the *Saturday Evening Post*) as follows:

Belgium	90 per cent
Italy	89 per cent
Great Britain.....	82 per cent
France	75 per cent
Japan	70 per cent
United States.....	51 per cent

"Why are Americans so apathetic?" quote the Editors of the *Bulletins* of the Genesee County and the Muskegon County Medical Societies, April 15, 1952.

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NEWS MEDICAL

"Why do so many of us sit back and 'Let George do it'?" Perhaps it is basically an unawareness of issues,

"Japan had a new-found individual freedom when 70 per cent of its voters cast their ballots. France and Belgium had just dropped the Nazi yoke. England turned to Churchill after years of Socialist rule. Italy arose against Communist infiltration. People in those nations really had something to vote about.

"Americans have something to vote about, too. Daily the issues are growing more clearly defined. The world needs a strong, sure America—and only Americans can keep our nation strong.

"Our role is clear. Whatever path we want America to take, *we* citizens at the grass roots must make the choice. We must study the issues. We must decide. We must vote. And as good citizens, we must do everything in our power to see that others register and vote, too—because today we Americans, of all the peoples of the world, have something vital to vote about!"

* * *

Another "pat on the back" re the Michigan Clinical Institute of 1952:

F. Hilton Smith, M.D., Salinas, California: "This is to thank you and your conferees for an excellent clinical program and for proving to be such pleasant hosts. The emphasis of your group on the practical side of things was particularly appealing, and has left me with an ambition to emulate it in our local society.

"I enjoyed the luncheon and the regional meeting on

trauma of the American College of Surgeons, but especially appreciated the opportunity of seeing new faces and new viewpoints in the common problems that confront us in our practices wherever they may be."

Thanks, Dr. Smith, and come back to Michigan soon.

* * *

John R. Rodger, M.D., of Bellaire, Michigan, is the author of an original article "Rural Practice Can Be Fun" published in the *Journal of the Student AMA*, April, 1952 number. Dr. Rodger relates to rural communities the following three questions so important to every medical student and intern: "Can I practice good medicine there?" "Can I make a decent living there?" "Will I enjoy making my home there?"

The Rodger article is worth while reading—not only for students but for practitioners of medicine.

* * *

Hill-Burton hospital construction in Michigan, as of March 31, 1952:

Completed and in operation: Eighteen projects at a total cost of \$14,383,781, including federal contribution of \$5,176,257 and supplying 943 additional beds.

Under construction: Seventeen projects at a total cost of \$18,766,002, including federal contribution of \$7,245,068 and designed to supply 1,122 additional beds.

Approved, but not yet under construction: Three projects at total cost of \$959,155, including \$531,183 federal contribution and designed to supply 62 additional beds.



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Kenneth B. Babcock, M.D., Detroit, was elected President of Michigan Hospital Service (Blue Cross) at a meeting of the Board of Trustees, April 24. Dr. Babcock succeeds E. Dwight Barnett, M.D., who recently resigned to become Director of Columbia University Institute of Administrative Medicine.

New medical members elected to the Executive Committee were Robin C. Buerki, M.D., and E. C. Baumgarten, M.D., both of Detroit.

* * *

S. L. Loupee, M.D., Dowagiac, long-time member of the Michigan Legislature, who resigned at the end of the 1950 session, was recently elected Mayor of Dowagiac.

Congratulations, Dr. Loupee!

* * *

More than 115,000 opportunities for professional work with handicapped children and adults await young people seeking careers, according to a new publication, "Careers in Service to the Handicapped" sponsored by the National Society for Crippled Children and Adults, Chicago, Ill. Lawrence J. Linck, Executive Director of the Society, states that current vacancies exist for an additional 4,000 occupational therapists, more than 16,000 physical therapists, and 12,000 to 15,000 speech therapists; 80,000 specially trained teachers are needed immediately to educate the nation's physically handicapped children.

For copy of the booklet "Careers in Service to the Handicapped" write Mr. Linck at 11 S. LaSalle St., Chicago 3, Illinois.

Cook County Graduate School of Medicine

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SURGERY—Intensive Course in Surgical Technic, two weeks, starting June 16, August 4, August 18.
Surgical Technic, Surgical Anatomy and Clinical Surgery, four weeks, starting September 8, October 20.
Surgical Anatomy and Clinical Surgery, two weeks, starting June 16, September 22.
Surgery of Colon and Rectum, one week, starting September 15, October 13.
Gallbladder Surgery, ten hours, starting June 16, October 20.
Basic Principles in General Surgery, two weeks, starting September 8.
General Surgery, one week, starting October 6.
General Surgery, two weeks, starting October 6.
Breast and Thyroid Surgery, one week, starting June 23.
Esophageal Surgery, one week, starting June 23.
Thoracic Surgery, one week, starting October 20.
Fractures and Traumatic Surgery, two weeks, starting June 16.
GYNECOLOGY—Intensive Course, two weeks, starting June 16.
Vaginal Approach to Pelvic Surgery, one week, starting September 22, November 3.
OBSTETRICS—Intensive Course, two weeks, starting September 29, November 3.
PEDIATRICS—Informal Clinical Course every two weeks.
MEDICINE—Electrocardiography and Heart Disease, two weeks, starting July 14.
Hematology, one week, starting June 16.
Gastroscopy and Gastroenterology, one week, Advanced Course, June 23.
UROLOGY—Intensive Course, two weeks, starting September 8.
Cystoscopy, ten days, starting every two weeks.
DERMATOLOGY—Intensive Course, two weeks, starting October 13.
Informal Clinical Course, every two weeks.
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In a recent article, "Pregnancy and TB," Jay Arthur Myers, M.D., of Minnesota reports: "It has become so general a practice in hospitals and offices of physicians to examine expectant mothers for tuberculosis that in this state of approximately three million people only one infant died from tuberculosis in 1950."

Michigan, with a little more than twice Minnesota's population, had nine tuberculosis deaths in infants under one year of age in 1950. There were also seven deaths in one-year-olds among a total of 35 in children under five.

Reprints of Dr. Myers' article may be obtained from:

MICHIGAN TUBERCULOSIS ASSOCIATION

The Michigan Crippled Children Commission sponsored an "Institute on the Crippled Child" in Grand Rapids, April 17-18-19. Co-sponsor was the Michigan Department of Public Instruction. Medical participants included James W. Rae, Jr., M.D., Ann Arbor, and Carleton Dean, M.D., Lansing.

* * *

The beginning dates of medical associations and of woman's auxiliaries was the subject of a recent survey by the West Virginia State Medical Association which reported that the beginning date of the Association year and of the Auxiliary year is the same in thirty-six of the forty-one states reporting, and different in but five states.

* * *

Tri-State Hospital Association "Key" of 1952 was presented to Mother Mary Carmelita Manning, R.S.M., Director of Hospitals for the Sisters of Mercy in Detroit. The award, made during the Tri-State Hospital Assembly in Chicago on April 29 and conferred by the Michigan Hospital Association, represents the highest award by that organization to an individual for meritorious service in hospital and health fields.

Mother Carmelita is well known to the medical profession of Detroit and of the entire State of Michigan. She was long the Mother Superior at Mt. Carmel Mercy Hospital, Detroit.

* * *

Grover C. Penberthy, M.D., Detroit, was guest speaker at the Iowa State Medical Society's 1952 Annual Session in Des Moines. Dr. Penberthy's address on April 30 was entitled "Some Surgical Problems of the Newborn and Infants."

* * *

The "Formula For Freedom" program will be presented in the Upper Peninsula on Friday noon, June 27, during the annual meeting of the Upper Peninsula Medical Society in Iron Mountain.

* * *

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"Upper Peninsula Day" will be celebrated at the 1952 MSMS Annual Session, Sheraton-Cadillac Hotel, Detroit, on Wednesday, September 24.

W. S. Jones, M.D., Menominee, is chairman of "Upper Peninsula Day," and his goal is to interest a high percentage of the membership of the Upper Peninsula's ten county medical societies to visit Detroit for the 87th Annual Session of the Michigan State Medical Society.

Detailed plans for "Upper Peninsula Day" will be published in subsequent issues of JMSMS.

MFME: Manistee County Medical Society members have developed a unique method of financial support for the Michigan Foundation for Medical and Health Education, Inc. Each year the members contribute \$10 each to the Foundation. This \$10, is collected annually at the same time the regular County Society dues are paid.

* * *

Waiting List for Operations.—The *Chicago Daily News* reports that in Britain, where medicine has been socialized for nearly four years, there are 124,587 persons waiting to be admitted to hospitals for operations. "There is a scarcity of both beds and nurses plus a bigger demand for operations which now are 'free,'" the story said.

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James J. Lightbody, M.D., Detroit, was toastmaster at the dinner during the Governor's Conference to Study Problems of the Aging held at Michigan State College, East Lansing, on May 12-13.

* * *

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* * *

Addressing the National Association of Chain Drugstores in Florida recently, Dr. R. B. Robins, Camden, Arkansas, former vice president of the American Medical Association and new president of American Academy of General Practice, lashed out at "big government" in Washington for regimenting the lives of the American people.

"The people's health," he said in his first speech as president of the American Academy of General Practice, "has in recent years become a verbal political football for public officials, legislators, bureaucrats, economists, and a wide variety of pseudo-experts with an uncertain knowledge of the subject."

"Unfortunately, far too many of the people who have been telling America how to solve its medical care problems are not qualified to do so. They not only have never diagnosed a case or filled a prescription, they have had no close practical connection with the many complex factors involved in medical care."

Dr. Robins, who is the elected Democratic National Committeeman from Arkansas, urged the chain druggists to take a more active civic role in problems relating to health.

* * *

New Secretary of Medical Education Foundation. The executive committee of the Board of Trustees announced recently a split-up of the secretarial duties of two American Medical Association groups—the American Medical Education Foundation and the Student AMA.

Activities of both groups have expanded at such an accelerated rate that one secretary can no longer serve both groups.

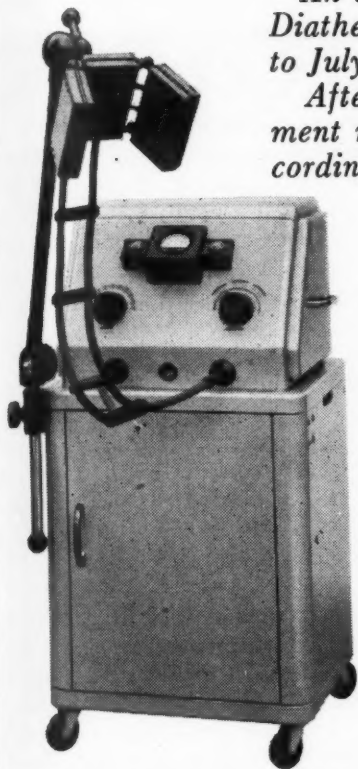
Russell F. Staudacher will devote full time to the job of executive secretary of the Student AMA and executive editor of its journal.

Hiram W. Jones, of Elmhurst, Illinois, who has been with the Research Council for Economic Security, Chicago, was appointed executive secretary of the American Medical Education Foundation. He formerly served as director of finance for the Chicago region of the National Conference of Christians and Jews and at one time was director of fund raising for Community Relations Consultants, Inc., specializing in hospital fund raising.

July 1, 1952

An important day for doctors still using Diathermy equipment manufactured prior to July 1, 1947.

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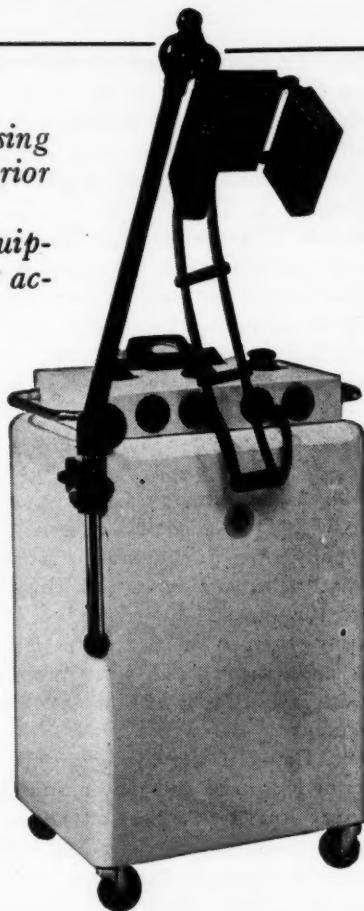


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Mr. Staudacher came to the A.M.A. in May, 1951, from Lansing, where he served as associate public relations counsel for the Michigan State Medical Society. During his tenure with both the Student A.M.A. and the foundation, great strides have been made.

Today, the Student A.M.A. has approximately 10,000 members in forty-four active chapters with twelve more provisional chapters being taken in next December.

During the first three months of 1952, the American Medical Education Foundation received more individual contributions than during the entire year of 1951. These contributions were received before the actual drive for funds—April 1 to June 30—got under way. The goal during that period is \$2,000,000.

* * *

The Atomic Energy Commission has begun negotiations with Dow Chemical Company and Detroit Edison Company on their proposal to continue for one year, on a jointly financed basis, the Dow-Detroit Edison study of greater industrial participation in the development of nuclear reactors for the production of fissionable materials and power. The work proposed by Dow-Detroit Edison is in line with the AEC reactor development program.

The Dow-Detroit Edison group is one of the four pairs of industrial and power firms participating in preliminary studies as a part of the industrial participation plan first recommended by Dr. Charles A. Thomas of Monsanto Chemical Company. Other groups are Monsanto and Union Electric of St. Louis; Commonwealth

Edison and Public Service of Northern Illinois, Chicago, and Pacific Gas and Electric and the Bechtel Corporation of San Francisco.

* * *

Polio cases are running slightly ahead of last year, according to reports from the Public Health Service. For the first three weeks of the "disease year" which began April 1, cases of poliomyelitis totalled 192 as against 152 for the same period last year. Public Health Service said states reporting largest numbers of cases were Texas 71, Louisiana 17, Florida 13, California 27, and New York 10. For the year ending March 29, total cases in the United States were 28,692 compared with 33,393 a year before. Both totals are reported as provisional.

* * *

The Army Surgeon General has requested commercial manufacture of a new self-gripping cotton bandage developed by Agriculture Department. Shrunk in a caustic soda solution and then washed in a dilute acid, the new bandage has a greater kinkiness, which gives it a non-slipping quality. Army has found them useful in holding burn dressings in place.

* * *

The Veterans Administration reports that 2,272 disabled veterans have received loans totaling nearly \$20.5 million for "wheelchair" homes. If they meet other VA requirements, veterans suffering loss or loss of use of lower limbs, requiring certain convenience devices in their homes, are eligible for loans of up to half the cost of the homes. . . . VA is issuing Prosthetic Service Cards to veterans using orthopedic braces, entitling the veteran to emergency repairs without prior VA approval.

* * *

The Third Symposium on Physical Medicine and Rehabilitation was presented by the American Congress of Physical Medicine and the American Society of Physical Medicine Rehabilitation, Michigan Group, in cooperation with the Veterans Administration Hospital, Saginaw, Michigan, on May 22, 1952, in the auditorium of the Veterans Administration Hospital, Saginaw. A practical program of discussion and demonstration of modern techniques of Physical Medicine and Rehabilitation in medicine and surgery was given.

The following program serves to outline present procedures utilized in commonly encountered pathological states:

1. "Physical Medicine and Rehabilitation—Modern Concept and Practice"—Dr. JAMES RAE, JR., Professor of Physical Medicine and Rehabilitation, University of Michigan School of Medicine and Director, Department of Physical Medicine and Rehabilitation, University Hospital, Ann Arbor, Michigan.
2. "Management of Circulatory Disturbances of the Central Nervous Systems Associated with Peripheral Paralysis"—Dr. M. K. Newman, Director of Physical Medicine and Rehabilitation, Grace Hospital and Detroit Memorial Hospital, Detroit, Michigan.
3. "Consideration of Problems Associated with Amputee Training and Prosthetic Devices"—Dr. Lewis



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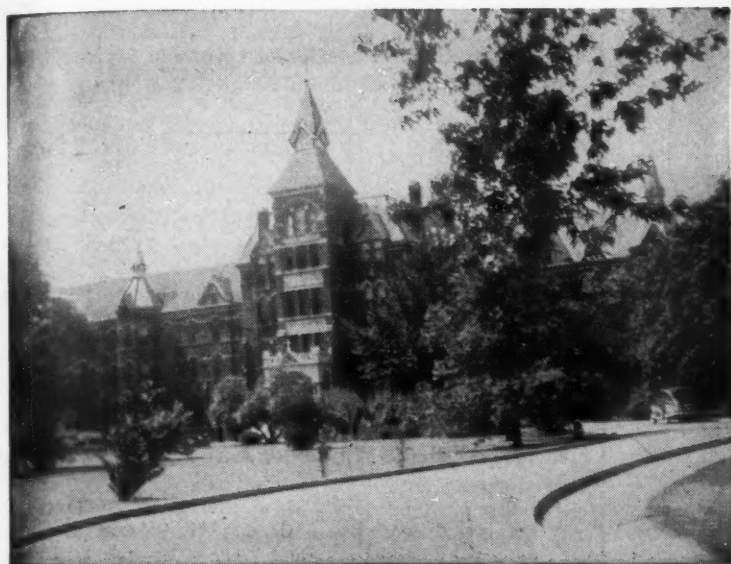
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Cohen, Acting Chief of Physical Medicine and Rehabilitation, Veterans Administration Regional Office, Detroit, Michigan.

4. "Management of Rheumatic and Arthritic States"—Dr. Joseph Markle, Director of Physical Medicine and Rehabilitation, Veterans Administration Hospital, Dearborn, Michigan.
5. "Utilization of Occupational Therapy Procedures in Rehabilitation"—Miss H. B. Jewett, R.O.T., Director of the School of Occupational Therapy, Wayne University, Detroit, Michigan.

A discussion and question period followed the presentation of the papers.

* * *

The Industrial Medical Association on April 23, 1952, presented the Knudsen Award to Max R. Burnell of Michigan and General Motors. This is the fourteenth annual presentation, and is given for the year's outstanding contribution to industrial medicine. Dr. Burnell was cited for the part he played in General Motors' contribution of more than \$1,500,000 to the University of Michigan for establishment of the Institute of Industrial Health. The Institute, dedicated to research, education and service in industrial medicine, recently began operation.

* * *

A Midwestern Cardiovascular Center specializing in the care of children with operable congenital malformations of the heart opened at the Children's Memorial Hospital, Chicago, on Wednesday, April 30.

Funds totaling \$30,000, available on an annual basis, have been allocated by the Children's Bureau of the Federal Security Agency to the University of Illinois Division of Services for Crippled Children for the establishment of the Center.

The potential area to be served by the Center includes the states of Ohio, Michigan, Kentucky, Indiana, Wisconsin, Minnesota, Illinois, Iowa, North Dakota, South Dakota, Kansas, Nebraska and Missouri.

* * *

As of April 1, 1952, 2,676 members of the Michigan State Medical Society had paid their dues to the County Society, and they had been forwarded to the office in Lansing. This is 546 more than last year, and, of these, 2,637 have included the AMA dues, a remarkable proportion, when the AMA dues are voluntary.

* * *

National Science Foundation fellowships for the academic year 1952-53 include more awards in the biological sciences than in any other one field. Of the 624 graduate fellowships granted, 158 predoctoral and postdoctoral awards went to biological science students with the remainder divided among students of chemistry, physics, engineering, mathematics, earth sciences, agriculture, astronomy and anthropology. Fellows receive stipends ranging from \$1,400 to \$3,000 plus certain dependent allowances.

* * *

Mississippi's 1,500 physicians were honored on March 30 when the state observed "Doctor's Appreciation Day."

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The occasion was set aside in a gubernatorial proclamation by Gov. Hugh L. White, who enjoined statewide observance in appreciation of the physicians' personal dedication to service.

The tributes to individual physicians were personalized in churches, civic clubs, and special gatherings where doctors were presented red carnations as tokens of appreciation. A number of local programs were conducted.

The event gained a lot of favorable support from the press and radio within the state.

IN MEMORIAM

(Continued from Page 777)

the University of Vienna, Knapp Memorial Hospital, New York Eye Hospital, New York Poly-Clinic and the University of Indiana.

At the time of his death, he was on the staff of St. Joseph Hospital Medical Center. Dr. Englehart was a member of the Houghton-Baraga-Keweenaw County Medical Society.

He is survived by a sister, Mrs. Hazel Allander of Hampstead, Maryland, and four brothers: Howard and Leon Englehart of Shreveport, Louisiana; Elwood Englehart of Charleston, North Carolina, and Earl Englehart, M.D., of Kingston, North Carolina.

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Acknowledgment of all books received will be made in this column, and this will be deemed by us as full compensation to those sending them. A selection will be made for review, as expedient.

ALLERGIC PRURITUS. ITS DERMATOLOGIC MANAGEMENT. By Stephan Epstein, M.D., Editor; Panel Discussion: Rudolf L. Baer, M.D.; Stephan Epstein, M.D.; Carl Laymon, M.D.; Francis W. Lynch, M.D.; Herbert Rattner, M.D.; Stephan Rothman, M.D., and James R. Webster, M.D. An official publication of The American College of Allergists, Inc. Saint Paul: Bruce Publishing Co., 1952. Price \$2.50.

This little book of seventy-six pages is a record of a "Symposium on Itching Dermatoses" presented at a meeting of The American College of Allergists. It does not go into the diagnosis and treatment of pruritic dermatoses from an allergic viewpoint but rather stresses treatment from the topical and systemic dermatologic viewpoint. Included is a good brief review of non-allergic dermatoses to be considered in differential diagnosis.

By noting the names of the panel members on this symposium, one will know this contribution is worthwhile. These physicians have presented time-tested dermatologic treatment methods which will help others to avoid making their patients worse by "overtreatment." This book will prove valuable to those not too familiar with topical therapy. It is up to date.

H. E. A.

FUNDAMENTALS OF PSYCHIATRY. By A. Strecker, M.D., Sc.D., LL.D., Litt.D., F.A.C.P., Professor of Psychiatry and Chairman of the Department, Undergraduate and Graduate Schools of Medicine, University of Pennsylvania; Psychiatrist to the Pennsylvania, Philadelphia and Germantown Hospitals; Consultant and Chief-of-Service, Institute of the Pennsylvania Hospital; Consultant to the Surgeons General, U. S. Army and U. S. Navy, and formerly Consultant for the Secretary of War to the U.S.A.A.F.; Senior Consultant in Psychiatry, Veterans Administration; Consultant in Mental Hygiene, U.S.P.H.S.; Chairman, Committee on Psychiatry, National Research Council; Chairman, Committee on Psychiatry, American National Red Cross. Fifth Edition. 21 illus. Philadelphia: J. B. Lippincott Co., Price \$4.50.

A fifth edition needs no introduction. It does seem necessary to point out that the author addressed this edition to general practitioners and workers in medicine and surgery. It is his hope that the basic principles of psychiatry will be stimulated in order to better treat the great number of psychoneurotics and psychosomatic disabilities that are seen in every doctor's office. He has listed all the various types of psychiatric and psychoneurotic reaction types. With each description of the illness he presents the psychopathology. For this reason a new chapter on psychotherapy has been included. This chapter gives an idea of the available treatment technics. He has rewritten his chapter on psychosomatic medicine. The author is one of the outstanding men in American psychiatry. He is able to speak authoritatively.

G.K.S.



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SURGICAL FORUM. Proceedings of the Forum Sessions, Thirty-seventh Clinical Congress of The American College of Surgeons, San Francisco, California, November, 1951. Surgical Forum Committee: Owen H. Wangensteen, M.D., F.A.C.S., Minneapolis, Chairman; Warren H. Cole, M.D., F.A.C.S., Chicago; Robert E. Gross, M.D., F.A.C.S., Boston; Michael L. Mason, M.D., F.A.C.S., Chicago; Carl A. Moyer, M.D., F.A.C.S., Dallas, and I. S. Ravdin, M.D., F.A.C.S., Philadelphia. Philadelphia: W. B. Saunders Co., 1952. Price \$10.00.

Perhaps you have wondered what is going on in the surgical research departments and clinics of the great Universities throughout this land? This book will answer your questions. Students of surgery will find it a remarkable convenience.

As Dr. Owen H. Wangensteen, Chairman of the Surgical Forum Committee of the American College of Surgeons, says in the foreword, "The progress of surgery in America from year to year will be documented and reflected in these volumes, which bid fair to become the vade mecum of the forward looking surgeon and the Arabian Nights' reader of that which is new and exciting in surgery." That about sums up what the reader may expect to find in this book. It is highly recommended to all surgeons and students of surgery.

J.W.H.

HAROFÉ HAIVRI—The Hebrew Medical Journal, Semi-Annual Publication, Moses Einhorn, M.D., Editor. Volume 1—1951. The Twenty-fourth Year. New York: The Hebrew Medical Journal.

DIAGNOSTIC BACTERIOLOGY. A Textbook for the Isolation and Identification of Pathogenic Bacteria. By Isabelle Gilbert Schaub, A.B., Technical Director, Clinical Bacteriology Laboratories, The Johns Hopkins Hospital; Instructor in Bacteriology, The Johns Hopkins University School of Medicine and the Nurses Training Schools, The Johns Hopkins Hospital and Sinai Hospital, and M. Kathleen Foley, M.A., Instructor in Bacteriology, Department of Biological Sciences, College of Notre Dame of Maryland; Formerly Bacteriologist in Charge of the Diagnostic Bacteriological Laboratory of the Medical Clinic, The Johns Hopkins Hospital. Fourth edition. St. Louis: The C. V. Mosby Co., 1952. Price \$4.50.

The reviewer was impressed with the terse and practical character of this book when he purchased the first edition 12 years ago and he has noted its improvement with succeeding editions. A small volume originally, it fortunately has remained this convenient size through the various revisions. It is more current than many new texts and even such recent procedures as the dilution-sensitivity tests for the newer antibiotics are fully outlined. While it may be of limited usefulness to clinicians, it is strongly recommended as a shelf reference in all laboratories and as a teaching aid for students in medical technology and bacteriology.

A.A.H.

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